Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Stakeholder Input Process

Prevention and Early Intervention
Special Topic Workshop

FRIDAY, APRIL 13, 2007 – RIVERSIDE
THURSDAY, APRIL 26, 2007 – EMERYVILLE

Summary

For Discussion Only

Table of Contents

I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed, culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

The meetings reported here, held on April 13, 2007 in Riverside and April 26, 2007 in Emeryville, were the first statewide stakeholder meetings focused on Prevention and Early Intervention (PEI). The two meetings used the same agenda.

Two hundred twenty-five (225) people attended the meeting on April 13, and 215 attended on April 26, for a total of 440 stakeholders. This summary reflects the combined content, questions and comments from both the April 13 and April 26 meetings.

II. Welcome, Introduction and Purpose of the Prevention and Early Intervention Special Topic Workshop

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, welcomed participants to the special topic workshop on Prevention and Early Intervention. She described the purpose of stakeholder meetings, including special topic workshops, technical conference calls and general update stakeholder meetings. Special topic workshops are designed to elicit stakeholder input on specific MHSA topic areas, while general update stakeholder meetings are intended to update the community about progress on MHSA components at the state level and to solicit feedback from stakeholders of a more general nature. Technical conference calls are used to bring stakeholders up-to-date on technical implementation issues. In the last few months, the process has included technical conference calls on the topics of housing, capital facilities and education and training and will address other topics, such as the integrated plan and IT in coming months. General update stakeholder meetings will be held two times a year, in three locations across the state: Northern, Southern and

Central California. Today's PEI special topic workshops will be followed by another set of two PEI special topic workshops in June 2007.

The purposes of the Prevention and Early Intervention special topic workshops on April 13 and April 26 were to:

1. Provide an overview of the PEI component and decisions.
2. Present outreach approaches to ethnic and underserved communities.
3. Answer questions.
4. Obtain initial oral and/or written PEI stakeholder input.

There were three primary ways to provide feedback at the special topic workshop. There was opportunity for oral questions and comments during the morning sessions in the large group, discussion in small breakout groups in the afternoon, and written comments throughout the meeting.

The morning session provided an overview of PEI and a discussion of outreach to underserved communities. The afternoon session was devoted to small group discussions with six groups discussing different topic areas. There were two afternoon discussion sessions held, which allowed participants to attend and provide feedback on two different topic areas. The topic areas for breakout sessions were:

- Trauma-Exposed Individuals.
- Children at Risk for School Failure.
- Suicide Prevention.
- Children and Youth in Stressed Families.
- First Onset of Psychiatric Illness.
- Children and Youth at Risk for Juvenile Justice Involvement.

Carol Hood, Deputy Director of DMH for the MHSA, in Riverside, and Emily Nahat, Chief, DMH Prevention and Early Intervention Branch, in Emeryville, presented an overview of MHSA implementation progress. To date, $1.7 billion has been deposited into the MHSA account. There are six components to MHSA, each of which is really a "mini-initiative" as described below.

- There was considerable attention initially given for community planning for Community Services and Supports (CSS). So far, $430 million has been distributed for CSS to counties to focus on unserved and underserved people with serious mental illness. During 2007, there will be expansion funding of $114 million for CSS.
- Housing funding applications for $400 million will be available in June 2007.
- Education and Training focuses the mental health workforce, providing better trained and newly trained staff. There is $200 million available for this component, of which half will go to local efforts and the other half will fund statewide programs.
- DMH is presently drafting guidelines for counties' IT and capital facilities programs, which should be posted in draft in May. Final guidelines will be posted three months

later, based on responses to the draft. There is $600 million available for this component this year.

- PEI is the newest component to be introduced to stakeholders. Because of funding gaps over the years, DMH has not been able to invest in prevention, despite its critical importance. Under the provisions of MHSA, PEI comes under both the Mental Health Services Oversight and Accountability Commission (OAC), which must approve expenditures and set policy and priorities, and DMH, which must provide guidelines for local plan requirements.
- Innovation is the final MHSA component to be implemented. OAC has responsibility for this component and is working with its Innovation Advisory Committee to set initial policies. The next step will be stakeholder input through special topic workshops.
- By July 2009, all MHSA components will be integrated with one another and with the existing mental health system. In order to achieve this goal, planning needs to start now. The first technical conference call on integration was held on April 25.

III. Overview of Prevention and Early Intervention

Jennifer Clancy, Executive Director of the OAC, and Emily Nahat, Chief, PEI Branch, DMH, presented an overview of the PEI component and the policies and processes that had been established to date. Documents providing OAC policy statements were disseminated and can be found on the MHSA website.

Ms. Clancy noted that, concurrently with the two workshops on PEI in April, the OAC held two public hearings on stigma and discrimination.

A. MHSOAC Recommendations on MHSA Prevention and Early Intervention: Key Policy Issues

MHSOAC and DMH have been working in close partnership for PEI. This process of state entities working together is, in and of itself, a powerful display of transformation.

1. Context for PEI Policy Development

Stakeholders have shaped many of the PEI policies. The OAC is made up of fifteen public members who are diverse advocates strongly committed to PEI, and their input and participation has been essential. Advocacy groups represented include the California Network of Mental Health Clients (Client Network), National Association for the Mentally Ill (NAMI), and United Advocates for California's Children (UACC). The OAC initiated the planning process for PEI more than a year ago.

The OAC's PEI committee made draft recommendations to the OAC for PEI policies that were adopted in October 2006. At the same time, the OAC adopted a process to

create draft requirements for the counties to follow. The OAC approved fifteen county and state PEI policies on January 26, 2007.

2. OAC PEI Policies

Policy 1: Key California Community Mental Health Needs
There is a challenging balancing act between state direction and the needs for local control. For state direction, there are five core mental health needs. The five core areas are:

- Disparities In Access to Mental Health Services.
- Psycho-social Impact of Trauma.
- At-Risk Children, Youth and Young Adults.
- Stigma & Discrimination.
- Suicide Risk.

The OAC PEI Committee was particularly concerned with homelessness and employment. These areas are also being addressed through the housing initiative and through the work on the five key mental health needs above.

Policy 2: Priority Age
PEI County Plans will be expected to address all age groups. However, a minimum of 51 percent of overall PEI county budgets must be dedicated to individuals between the ages of birth and 25. Small counties are excluded from this policy.

Small County Definition: A "small county" is defined as having a population of fewer than 200,000, as determined by the latest population estimates from Department of Finance. While just over half of California's counties meet that criterion (30 of 58 counties), they represent less than 6 percent of the state's total population.

Policy 3: Priority Populations

- ***Underserved Culturally Diverse Populations:*** This is a broad term, and while these funds are limited, the Commissioners are interested in increasing access to PEI services by culturally-diverse populations. In June, the OAC will discuss whether it should target culturally diverse communities. Racism and discrimination uniquely place people at risk for mental and physical health issues.
- ***Individuals Experiencing Onset of Serious Psychiatric Illness:*** There are different interpretations of "onset." However, OAC refers to any onset. This goes beyond schizophrenia to encompass a broad definition of mental illness.
- ***Children and Youth in Stressed Families:*** Local communities need to define this for themselves: it could include such issues as violence, immigration, involvement with law enforcement or others identified and justified by the counties.
- ***Trauma-Exposed:*** Local communities need to define this term, which could include violence, interaction with the systems, immigration or other concerns that are identified by the local community.

- ***Children and Youth at Risk for School Failure:*** Local communities need to define this term.
- ***Children and Youth at Risk of Juvenile Justice Involvement:*** The Commission is still considering whether to include youth in the juvenile justice system as a priority population for PEI.

Policy 4: Recommended PEI Programs, Interventions, and Strategies

- PEI County Plan Requirements will suggest programs, interventions and strategies that have been identified through research and the stakeholder process.
- DMH statewide projects would also support these selected programs, interventions, and strategies on a statewide basis.
- Counties will have the ability to select county alternatives, so long as the alternatives are justified in their plans.

Policy 5: Priority Principles

Approval of PEI County Plans will be based on demonstration of the PEI Principles and Criteria defined in the OAC PEI Recommendations adopted in October 2006 and on meeting criteria in the proposed guidelines.

Policy 6: Distinction between PEI and CSS

The money available through this component of MHSA is less than is actually needed. As a result, there needs to be a clear distinction between PEI and CSS. Operational definitions will be determined by DMH in terms of such issues as the nexus between early intervention and treatment. At the same time, counties will have flexibility in their implementation of these definitions, as long as justification is provided.

Policy 7: Priority Long-term Outcomes

Priority outcomes defined in the Act are the 7 Overall Aims of the MHSA:

1. Reduction of school failure.
2. Reduction of homelessness.
3. Reduction of prolonged suffering.
4. Reduction of unemployment.
5. Reduction of incarceration.
6. Reduction of removal of children from homes.
7. Reduction of suicide.

Counties will work toward achievement of those outcomes. Not every county will be expected to address each outcome; individual counties will differ in outcomes addressed given their local priorities.

Policy 8: Short-Term Goals, Evaluation Methods and Accountability Reporting
County Plan PEI requirements will include short-term goals, a set of required outcome indicators, and evaluation methods for PEI that are applicable at the state and county levels. DMH will organize an Evaluation Work Group with representation from consumers, family members, program and evaluation experts in prevention and early intervention, California Mental Health Planning Council (CMHPC), California Mental Health Directors Association (CMHDA), OAC and other critical partners, to shape recommendations for statewide PEI outcome accountability.

Policy 9: County Planning Process
The County PEI planning process will replicate the logic model used for CSS. MHSOAC and DMH want to improve the process by integrating lessons learned from the CSS process. Counties will be asked to identify their individual priority community needs, populations, strategies and outcomes.

Policy 10: State-Administered Project: Suicide Prevention
MHSA has a fund of $14,000,000 annually for four years dedicated to suicide prevention. There will be a statewide committee to advise on a strategic plan for suicide prevention. In addition, there will be $500,000 per year for two years for statewide suicide prevention strategic planning.

Policy 11: State-Administered Project: Stigma and Discrimination Reduction
MHSA has a fund of $20,000,000 annually for four years to address stigma and discrimination. Concurrently with these two PEI special topics workshops, OAC also sponsored meetings specifically on stigma and discrimination. The Policy Writing Workgroup, established by the OAC and led by the Center for Reducing Health Disparities, UACC, California Youth Connection, the Client Network, and NAMI, will develop stigma and discrimination reduction priorities and strategies. This work is overseen by the OAC Representative Advisory Group. Priorities and strategies will be reviewed at two public hearings, coordinated with PEI special topic workshops. Strategies will be presented to the full OAC for action at its May 2007 meeting. Based on OAC action, DMH will then produce a cost analysis for OAC approval prior to implementing the program.

Policy 12: State-Administered Project--Training, Technical Assistance and Capacity Development
MHSA has a fund for PEI training and technical assistance of $12,000,000 annually for four years. Statewide training serves as an incentive, not a requirement. The goals of statewide training are to:

- improve the capacity of partners outside of the mental health system; i.e., education, law enforcement officers, primary care providers;
- to assist in prevention and early intervention efforts; and

- to develop capacity to do PEI work.

Policy 13: Statewide Evaluation
There will be an investment of up to 5-8 percent of the MHSA county PEI fund to be spent annually on statewide PEI evaluation. To the extent possible, statewide evaluation will be paid for by the MHSA administrative budget. Counties need to be intimately involved in the evaluation design to ensure that it is effective. MHSA can have a national impact on PEI programs: what happens in California can affect mental health throughout the country.

Policy 14: Prudent Reserve
A statewide prudent reserve for PEI will be created from 2005-2006 PEI revenue. This reserve will allow MHSA to maintain stability over time, to protect against fluctuations in the state's economy and the resultant tax revenues. The prudent reserve will be the equivalent of 50 percent of the PEI service funds. County-specific amounts will be shown in the county sub-accounts.

Policy 15: Ethnically and Culturally Specific Programs and Interventions
There will be a MHSA fund of up to $15,000,000 annually for four years to support special projects for reducing ethnic disparities, based on the results of the ethnic community stakeholder process. It is important to remember that all county PEI plans must address the reduction of disparities in ethnic communities; these funds are for projects above and beyond the basic plan requirements for all counties.

3. Prevention and Early Intervention Values, Vision, Partners and Rationale

PEI Values
- Collaboration.
- Reducing disparities.
- Expanding services while improving other key systems in the community.
- Leveraging other funds and resources.
- Having a focus.
- Making an impact.

PEI Vision Statement
All Californians share responsibility for promoting strong mental health and resiliency among individuals in their many diverse communities and for supporting individuals in accessing mental health services without fear of disapproval or discrimination.

Prevention and early intervention approaches are tools for empowerment and social justice that emphasize holistic and integrated approaches to mental health.

Partners in Prevention and Early Intervention
DMH, OAC, California Mental Health Planning Council (CMHPC), California Mental Health Directors Association (CMHDA) and consumers, family members and other statewide and community stakeholders have all worked together to develop the PEI component.

Why Invest in Prevention and Early Intervention?
- Positive, proactive approach vs. fail first system.
- Cost effective--investing in PEI reduces the need for more costly mental health treatments, special education and welfare supports later.

4. PEI Requirements and Definitions

PEI Statutory Requirements
- Prevent mental illness from becoming severe and disabling.
- Recognize the early signs of potentially severe and disabling mental illnesses.
- Access and linkage to medically-necessary care.
- Reduction in stigma.
- Reduction in discrimination.

PEI Definitions and Issues

Three Levels of Prevention
Prevention interventions may be classified according to their target groups (from the Institute of Medicine):

1. **Universal**: Targets the general public or a whole population group that has not been identified on the basis of individual risk. (Example: education for school-aged children and youth on mental illnesses and contact with clients to reduce stigma.)

2. **Selective:** Targets individuals or subgroups whose risk of developing mental disorders is significantly higher than average. (Example: support group for elderly widows.)

3. **Indicated:** Targets individuals who are identified as having signs, symptoms, or genetic markers related to mental disorders, but who do not currently meet diagnostic criteria. (Example: parent-child interaction training for children identified by their parents as having behavioral problems.)

Prevention is targeted for individuals, to address potential emotional issues or mental illness at the earliest stages, such as maternal depression. MHSA's PEI component will allow mental health workers, local communities and the state to focus on new roles in the mental health community, where resources have only addressed individuals with the most serious mental illnesses.

5. Prevention and Early Intervention Next Steps and Timeline

- Stakeholder input--three-part process which expands stakeholder voices:
  - General, large stakeholder meetings to review Guidelines.
  - Ethnic-specific stakeholder process.
  - Transition-age youth stakeholder process.
- DMH development of local plan guidelines:
  - Operational definitions of PEI.
  - Recommended strategies: there will be a wide range of approved strategies, based on research and the feedback from the three-part stakeholder process.
  - Accountability/evaluation framework will be available in draft form before or at the June PEI special topic workshop.
- County plan submission and funding.
- State-administered projects--planning and implementation.

Task	***Date***
Release draft local plan guidelines to general stakeholders	June 2007
Broad stakeholder review of draft local plan guidelines – 2 special topic workshops (North and South)	June 2007
Release Information Notice — Planning funding	July 2007
Release Information Notice — Final PEI guidelines and funding	August 2007
County plan submission and review	November 2007-Ongoing
County plan approval/contract amendment	January 2008 -Ongoing

Contact Information
MHSOAC:
Phone: (916) 445-1104
Fax: (916) 445-1577
Email: mhsoac@dmh.ca.gov
Mail: 700 N. 10th St, Suite 202, Sacramento, CA 95814
Website: http://www.dmh.ca.gov/MHSOAC/default.asp.

DMH:
Phone: (800) 972-6472 (MHSA)
Fax: (916) 654-6394
Email: mhsa@dmh.ca.gov
Mail: Attn: MHSA
California Department of Mental Health
1600 Ninth Street, Room 250
Sacramento, CA 95814
Website: http://www.dmh.ca.gov/MHSA

B. Stakeholder Comments and Questions

Age Group Priorities: 0-5

- **Stakeholder Comment:** Consider making maternal depression a priority. It has a profound effect on the child and family.
  - **MHSOAC Response (Jennifer Clancy (JC)):** PEI policy development has been a yearlong process. The MHSOAC will not make changes at this time. At the county level, each county can make it a priority, as long as their plans reflect how it relates to a priority area (e.g., trauma or stressed families). Each county will have to show how these broad-based priorities are reflected in their communities. The charge is to think creatively.
- **Stakeholder Comment:** Maternal depression is serious. First 5 both wants to see this focus on children 0-5 and recognizes that it crosses every population and issue.
- **Stakeholder Comment:** Within programs for children with developmental disabilities, it is important to help bridge peer support services, and to bridge family access to mental health services. There are a lot of restrictions and barriers; for example, many families do not have health insurance. Some families need support that is more professional. As counties develop priorities, it would be good for them to fund groups that will help parents and young children.
- **Stakeholder Comment:** The Infant Development Association appreciates emphasis on children. Children 0-5 should be recognized as a priority population because they represent the ideal time to provide prevention. Children in this age group often get lost in programs. Mandate that planning processes address age-specific priorities, otherwise the needs of young children will be lost. Consider the lack of services and qualified personnel in the early childhood system; otherwise the system will be one focused on treatment rather than prevention.
- **Stakeholder Comment:** Designate 0-5 a priority age as an optimal point of intervention. Based on the literature supporting the efficacy of early intervention for this age group, provide guidance to all counties, including small counties, on the development of plans that include strategies for developing mental health prevention, early intervention and treatment services for children 0-5 and their families.
- **Stakeholder Comment:** Will the exclusion of small counties from the requirement of 51% of funding for children and youth in PEI county plans be permanent or temporary?
  - **MHSOAC Response (JC):** MHSOAC does not expect a change in that policy for three years. MHSOAC will look at program evaluations to see what policy changes are needed in the future.
- **Stakeholder Comment:** People in rural counties who care about children's mental health are very concerned about the small county exclusion of the MHSOAC policy of 51% of funding dedicated to children. In CSS, oftentimes young children were left out. Unless the requirement is there, small counties will ignore it. Especially considering the statement that policies will not change in the next three year cycle, please reconsider this small county exclusion.

- **Stakeholder Comment:** Add “lack of service availability for young children” to the causes of disparities in access to mental health services that PEI efforts seek to reduce. For children 0-5, access is limited most severely by this issue. Some counties have very few services for young children. A growing number of counties have begun developing treatment services using county mental health funds or EPSDT funding. But even in those counties, services are limited in availability. EPSDT-funded treatment services are available only to children who are full-scope Medi-Cal eligible, while little is available for children who are not. Access to preventive intervention services for at-risk young children is even more limited, due to a lack of funding. Some counties have developed innovative approaches through their First 5 county organization, such as mental health consultation to child care programs. Such efforts vary from county to county, and sustainability often is the issue.
- **Stakeholder Comment:** Add “the critical shortage of qualified early childhood mental health specialists” to the causes of disparities in access to mental health services for young children that PEI efforts seek to reduce. There is a severe shortage of qualified early childhood mental health professionals in all parts of California. Many counties, particularly rural counties, cannot find qualified service providers, even if funding for services for young children is available in California. This critical shortage will be a key factor affecting implementation of county PEI plans for young children.

Age Group Priorities: Transition Age Youth

- **Stakeholder Comment:** The federal government’s attempt to micro-manage parenting is a problem. That sort of thing is counterproductive. Some of this is a fear of teenagers. There is a total refusal of acknowledgement that family background, for example, or inconsistent parenting, does have an effect on children and mental illness.
- **Stakeholder Comment:** Many times the first acknowledgement of mental illness is relationship with criminal justice. People 18-30 should be included in the PEI priority groups.
    - **DMH Response (Emily Nahat (EN)):** People 0-25 are included in priority age groups. Adults ages 25-30 might fit into other categories, such as trauma-exposed.

Age Group Priorities: Older Adults

- **Stakeholder Comment:** California has an aging population that will only grow as the Baby Boomers age, and suicide is a big problem among seniors.
- **Stakeholder Comment:** Older adults have many disabilities and disorders. They often cannot take care of themselves.
- **Stakeholder Question:** The age priorities are unfair. There are seniors who may not be able to get their medications. Families are taking care of older adults and this causes stress. PEI needs to pay for seniors and older adults. What about trauma done to older adults?
    - **MHSOAC Response (JC):** 49% of the funding can be dedicated to all ages. There has been a lot of feedback about the needs of older adults. The CMHDA

raised this issue. However, it is important to note that 75% of all serious mental health issues appear by age 24.
    - **DMH Response (EN):** Suicide crosses all age groups. There is not a cut-off for age. MHSOAC and DMH are not excluding any age group. These strategies need to be used for all age groups. A county could include older adults in strategies such as trauma-exposed individuals or stressed families.
- **Stakeholder Comment:** Because no breakout sessions are geared for elders, it sends the message that elders do not matter. Meetings are ineffective because one person monopolizes the meeting and the facilitator does not take control. Professionals are disrespectful. Doctors make referrals for inpatient treatment rather than listen to people. A history of child abuse and sexual trauma at a young age increases the risk for mental breakdown and suicide.
- **Stakeholder Comment:** What about older adults in PEI?
    - **DMH Response (JC):** While older adults are not an age priority, most with mental health issues fit into many of the priority issues, such as trauma.

Native American Priorities

- **Stakeholder Comment:** Thank you for coming to the Bay Area so that local people could attend. Emeryville is Ohlone land. Thank you for not holding the meeting on an Ohlone burial site. Discrimination is a major issue for Native Americans. Racism and discrimination causes many health issues. The Diagnostic and Statistical Manual (DSM) should reflect racism within its diagnosis for mental illness.
- **Stakeholder Comment:** Everyone needs to come together to take care of the children. The children need mental health services and families in diverse communities need people to understand the cultural needs and histories. Someone who has never been through trauma will not be able to understand the needs of those who have. Native American Health Center understands and takes care of people who are trauma-exposed and helps them to find their voices. Poor, insensitive care and separation from one's children creates separation anxiety on the child's part as well as resentment, and will cost the state more money in the end.
- **Stakeholder Comment:** Services generally are not working for trauma-exposed people. However, Native American Health Center had a great wraparound program with effective classes, but these classes are only for people with substance abuse issues or people who are dual-diagnosed. The funding streams are problematic. It is important to have positive role models. Make funding available for Native American Health Center.
- **Stakeholder Question:** The urban Indian population is larger than the rural Indian population. Native Americans have developed their own systems of care based on people helping people. The CSS process was overwhelming and Native Americans had trouble participating. It is good to see so many Native Americans here today. Listen to how Native Americans experience wellness and the techniques they use to make people healthy, spiritually and emotionally. The amount of money spent on mental health services for Native Americans is very low. Please increase it. Address family dynamics, where communication and parenting may not be effective. Although there is a billion dollars allocated for mental health services in California, many Native American clinics lost funding. Fix this problem this time.

- **MHSOAC Response (JC):** The issue of what happened during the planning process on the local and state level for CSS is under discussion. It was a learning process for everyone. DMH and MHSOAC are trying to bring everyone into the process. Counties have to use their logic model, but also need to bring in cultural communities. MHSOAC wants to provide training money for counties to help bring in diverse stakeholders.

- **Stakeholder Comment:** Native American beliefs and culture can help with mental health issues. That support has been diminished through funding cutbacks. Provide the proper funds for Native Americans.

Law Enforcement and Incarceration

- **Stakeholder Question:** PEI must address the pitiful and sometimes horrific ways people with mental illness are treated by law enforcement. All that was heard from law enforcement in the CSS process was, "When are we going to get money? We will not change until we get money." This crosses age groups.
  - **MHSOAC Response (JC):** There is a strong need to have collaborative programs with law enforcement, especially programmatic partnerships. MHSA money can be an important catalyst, but MHSA should not take on the responsibilities of our partners. These partnerships are important and MHSA dollars are limited.
- **Stakeholder Comment:** There needs to be a program to divert children away from initial contact with the juvenile justice system. It is better to provide services before juvenile justice involvement. Afterwards, many become suicidal and depressed and it is too late.
  - **DMH Response (EN):** That is the purpose of children and youth priorities, to identify at-risk children at very early stages. Counties are already working on this.
- **Stakeholder Comment:** There is substantial stigma among prison population. There needs to be programs for people being released. There also needs to be trans-generational programs.
- **Stakeholder Comment:** Clients have not agreed with language about stigma, as there has not been enough time for client input. This is not just about incarceration and law enforcement. This is about prevention of incarceration. PEI strategies to prevent both discrimination and incarceration should include a program that hires client/survivor outreach workers and researchers to conduct a series of studies throughout the state in order to identify juvenile and adult service providers, schools, police and probation departments that profile people based on perceived mental health disability, race and homeless status. The program should then require agencies identified as having used discriminatory profiling methods to be re-trained, and hire a team of clients/survivors and legal advocates to train the staff of those agencies in client culture and anti-discrimination law, including all levels of management. Agencies that have received more than three separate complaints of discriminatory practices should be required to pay fines based on their revenue; these fines should fund the re-training portion of this program.
- **Stakeholder Comment:** PEI programs that prevent incarceration should always be truly voluntary and self-directed, never coercive or forced. Examples of coercive

programs that should not be recommended or funded include mental health courts and coercive jail diversion programs for youth or adults.

- **Stakeholder Comment:** PEI strategies to prevent discrimination and incarceration should include client/survivor-run peer advocacy groups to support client/survivors of police abuse and those who are at risk. A client/survivor-driven, anti-oppression model should always be truly voluntary, free from coercion or force; clients must always have the option of refusing any and all treatment offered without facing jail or hospitalization. A client/survivor-run training program should be developed for consumers/survivors to provide this type of support and prevent crises. Please see the California Network of Mental Health Clients' report, *Normal people Don't Want to Know Us: First-Hand Experiences and Perspectives on Stigma and Discrimination: Selected Excerpts from the Report-in-Progress,* by Delphine Brody, available on the Client Network's website, for further information.
- **Stakeholder Comment:** Clients/survivors can often de-escalate potential crisis situations, such as disputes with family members or partners, much more effectively than police. PEI strategies to prevent discrimination and incarceration should include a client/survivor-run pilot program allowing a county to dispatch a mini-support team of clients/survivors to the scene instead of police, so the problem does not escalate any further. This can often prevent problems from getting worse without involving the police.
- **Stakeholder Comment:** PEI strategies to prevent discrimination and incarceration should also include a client/survivor-driven public education campaign on how to respond to people in emotional distress in other ways besides calling 911, because this all too often results in clients/survivors being unnecessarily killed, or arrested and either taken to jail or hospitalized. The public needs to know that peer support can be more effective than calling 911.
- **Stakeholder Comment:** PEI strategies should also include a crisis-prevention warm-line, so clients can reach peers easier in situations like these. This would give clients a way to approach others like them, who can listen and help them calm down.
- **Stakeholder Comment:** This meeting is an amazing accomplishment. It is important not to make blanket statements about law enforcement and mental health, but rather let people speak from their own experience. Orange County has an amazing collaboration between law enforcement and mental health advocates with a 59 member steering committee.

Gaps

- **Stakeholder Comment:** There need to be more clubhouses for clients who get as much from clubhouses as from other services or programs. It is a place for people with depression to go.
  - **DMH Response (EN):** This is a very important strategy for CSS and for PEI, for people with early onset, across all priorities.
- **Stakeholder Comment:** 48% of people who commit suicide go to primary care providers and 30% of people who commit suicide go to their primary care providers within a month of their suicide. A vital part of suicide prevention is training primary care providers to understand the signs and know what to do when they see them.

- **Stakeholder Comment:** There is nothing about how mental illnesses relate to physical illnesses, such as the link between diabetes and dementia.
- **Stakeholder Question:** Substance use weaves through all these PEI issues. Use of substances often masks and increases trauma exposure. There is a lack of participation with the substance abuse field throughout the state. What is the strategy for addressing substance use and of bringing the experts to the table? The alcohol and drug field has many best practices.
    - **DMH Response (JC):** These are critical comments. There is a long history of how trauma exposes people to mental health risks. MHSOAC held a meeting on co-occurring disorders and learned about trauma, substance use and co-occurring disorders. The priorities are very broad categories so counties can define their needs as appropriate to their areas.
- **Stakeholder Comment:** As a parent of an 18 year old who just got out of a residential treatment and fought to get him services through special education, it is clear that parents do not receive adequate information about what services are available, how to negotiate the maze of special education and community mental health services and what options might be available and might work for children. A brochure for parents is being developed to fill this need.
- **Stakeholder Comment:** Children and youth who have achieved permanent homes through adoption have different issues than families in which children are born into their families. These families suffer additionally because professionals are not competent to address this difference.

Collaboration and Partnerships

- **Stakeholder Comment:** Subsidized housing providers are experienced in housing older adults but do not have adequate experience or training to serve people with mental health issues. Provide training in how to do this well.
- **Stakeholder Comment:** The Mental Health Association has a list of recommendations that were developed with a group of community-based organizations (CBOs) representing a wide range of communities. The RFPs need to include CBOs that specialize in serving families and children in their communities. CBOs should be in the planning process and not precluded from providing services.
- **Stakeholder Comment:** Health centers were largely omitted from CSS plans. For example, Ventura County left health centers out, although health centers provide significant culturally competent mental health services.
    - **DMH Response (EN):** During the planning process, counties should include community clinics. Mental health and physical health integration is an important strategy to include in all areas.
- **Stakeholder Comment:** Just as clinicians have to have hope when working with clients, it is important to share the hope that community health centers will be included in the PEI planning process and funding. Community health centers are an ideal place to make a difference in reducing disparities. Many people come to community health centers for mental health services, seeking confidentiality. Community health centers help to reduce stigma.
- **Stakeholder Comment:** A mother of a 15 year old with severe emotion disturbance who has become violent and threatened to kill himself and his family called out for

help. While parents called the police, law enforcement arrested and then released him from the 5150 hold because the mental health evaluator did not see a reason to hold him, despite the extensive injuries he inflicted on his brother. The school system will not help or provide services. Parents are unable to afford to send him to a residential program. This is a disaster waiting to happen and help is needed.

- **Stakeholder Question:** How closely are schools and DMH following the guidelines for the federal program, "Achieving the Promise"? Dr. Mayberg, along with 23 other experts, spent a year looking into this issue.
  - **DMH Response (**EN**):** The policy guidelines are informed by the federal guidelines, as was the selection of target populations. However, more comments about how DMH could better match these guidelines are welcome.
- **Stakeholder Comment:** The most underserved community is the school system. At the same time, it is a universal setting for children and families. Some districts already have many excellent partnerships while others do not.
- **Stakeholder Comment:** It is fitting that the California Department of Education (CDE) is a major partner. School psychologists are in a position to identify children with mental illness. It should be part of the curriculum to teach students about mental illness.
  - **DMH Response (EN):** DMH has a growing partnership with CDE and has programs in the schools.
- **Stakeholder Comment:** Each person has so much passion about his or her issue and there are so many important issues. Stigma and access to mental health services are big issues for students and often schools can help. There are many schools with mental health services on campus and they have found that students are more likely to come to services within the campus than to follow through with referrals in the community. Consider offering more services on more school campuses.

MHSA/PEI Requirements and Clarification

- **Stakeholder Comment:** How will issues of supplantation work in terms of the difference between enhancing and expanding already existing services?
  - **DMH Response (EN):** DMH wants to see enhanced services and anticipates that MHSA funding will leverage resources so that services or programs that exist already can be enhanced, not funded in total, but funded for specific components. For example, school programs that address substance abuse or safety might add a component about behavioral health or senior meals programs might add some behavioral health screening or education and MHSA would pay for that specific piece.
- **Stakeholder Question:** There is concern about distinction between CSS and PEI dollars. Traditional treatment does not seem to work for people in transition from early symptoms to onset to serious mental illness. Funding is generally in silos that do not work. Integrated services do work. Rethink intensive treatment at this early time as prevention of long-term disability.
  - **DMH Response (EN):** Contact Beverly Whitcomb at DMH's MHSA staff for more information. An integrated plan is very important.
- **Stakeholder Question:** Are there exclusions for individuals with early onset?

    - **MHSOAC Response (JC):** When this priority was first discussed, people called it first break, which generally refers to schizophrenia. DMH and MHSOAC changed the name to first onset in order to assure there would be no exclusions.
- **Stakeholder Question:** Why is DMH only looking at short term funding for PEI? San Joaquin County is developing a program that will start with young children and gradually become a lifelong program. These programs need to be long-lasting.
    - **MHSOAC Response (EN):** There is no time limit for prevention, but there will be time limits on the early intervention.
- **Stakeholder Comment:**. There seems to be a disconnect about first onset versus prevention.
    - **DMH Response (EN):** Identification of first onset and early intervention present an important exception in terms of intensity and duration. Identification of early onset can be helped with low intensity services. Counties should talk about early signs, where early intervention will be provided. Early intervention can eliminate the need for more intensive treatment. This is a refinement still to be made.
- **Stakeholder Question:** How will local plans integrate with the CSS and the integrated plan?
    - **DMH Response (Carol Hood (CH)):** Many of the programs funded in the early years will likely continue into the integrated plan.

Stigma

- **Stakeholder Comment:** Consider a public service announcement (PSA) of people doing regular activities in which each one in turn speaks to the camera and says, "I've got diabetes and I'm a human," "I've got cancer and I'm a human," and "I've got mental illness and I'm a human."
    - **MHSOAC Response (JC):** There is both statewide and local funding. MHSOAC is working to identify strategies that stakeholders think will be effective at a state level and at the local level. PSAs are a potential strategy. This will come up at the May MHSOAC meeting.
- **Stakeholder Question:** The Carbinieri program for teen suicide, with a drop-in center, is a good program. There have been a number of programs there. But there is stigma about attending.
    - **DMH Response (EN):** There is a lot of work to be done on stigma. But communities have many after school programs for youth. It may depend on how the programs are publicized and promoted.
- **Stakeholder Comment:** Requirements for PEI include suggestions for campaigns for stigma reduction and to have materials to conduct such campaigns locally.

Cultural Competence

- **Stakeholder Comment:** Value cultural competence.
- **Stakeholder Comment:** Direct money to ethnic and diverse populations that have historical trauma, which is not addressed in the DSM IV, but has impacts on community, family and individual levels. Cultural communities know how to work with this issue on a holistic basis, and this should be incorporated into MHSA services.
- **Stakeholder Comment:** A cultural approach is important. Until DMH includes Spanish interpretation at these events, including translation of the materials on

screens, cultural competence and inclusion will not be achieved. It is important to utilize people who are bicultural as well as bilingual to assure that meaning is correct.
    - **Pacific Health Consulting Group Response (Bobbie Wunsch (BW)):** DMH is happy to provide interpretation services and translation of materials in any language, as long as they have advance notice of the need to make interpretation and translation of materials available.

Other Issues

- **Stakeholder Comment:** All programs mentioned are very important, but it is important not to lose focus on severe mental illness. A program in Portland, Maine decreased hospitalization by 35%. Counties and the state have to prioritize how to spend the money because they will not be able to cover everything.
    - **MHSOAC Response (JC):** This important issue was raised earlier in the process, and MHSOAC recognized that CSS was focused on severe mental illness. PEI is meant to prevent the onset of severe mental illness. MHSOAC and DMH are trying to be very clear about the difference.
- **Stakeholder Comment:** Stress spirituality, an important aspect of recovery for many people.

IV. Outreach to Ethnic and Underserved Communities

Sergio Aguilar-Gaxiola, MD, PhD, Director, UC Davis Center for Reducing Health Disparities, presented information about DMH's efforts to outreach to ethnic and underserved communities for input into MHSA components, especially PEI.

A. Presentation

MHSA and Disparities

- Reduction of disparities in mental health and access to mental health care was a central goal of MHSA. How do we do it? What are the problems that underserved communities experience and report? How can mental health services better address the needs of the underserved?

Where are the disparities?

- Groups historically underserved by mental health services.
- Groups facing geographic or linguistic barriers to care.
- Mental health priority populations.
- Groups with high uninsurance, underinsurance and/or poverty rates.

Learning How to Reduce Disparities

- We need direct input from underserved communities. This is not an easy task. Underserved communities may be:
    - Unaware of potential benefits.
    - Not ready to participate in policy process.
    - Suspicious and distrustful of mental health services.

Project Goals

- Conduct outreach to communities that have been underserved by public mental health services and not included in previous community stakeholder processes.
- Develop a community engagement process to ensure direct input from underserved communities based on:
    - Respect and mutual trust;
    - Investment in community relationships;
    - Collaborative action aimed at soliciting input regarding communities' needs and perspectives.
    - Solicit and gather input regarding Prevention and Early Intervention programs, priorities, and strategies.

Principles of Community Engagement

Community engagement processes are about personal and local relationships that should be:

- Participatory.
- Cooperative.
- Conducive to learning from each other.
- Encourage community development and capacity building.
- Empowering.
- They should identify assets, strengths and resources within communities.

Outreach Methods

- Identify specific underserved communities.
- Interview key informants to focus on specific needs within communities.
- Work with "cultural brokers" or community health representatives to develop outreach strategies.
- Conduct focus groups with community members about mental health needs, community assets, etc.
- Provide feedback to communities about the impact of the information collected on policy and services.

Preliminary Findings: Key Themes from Interviews and Focus Groups

- Lack of housing.
- Exposure to trauma.
- Poverty.
- Social isolation.
- Linguistic barriers.
- Discrimination.
- Lack of access.
- Shame.
- Mistrust of the "system."

Preliminary Findings: Community Assets

- Social networks and supports (varies across groups).

- Community based-grassroots organizations providing much needed services.
- Outreach workers.
- After-school activities (when available).

Preliminary Findings: Mental Health Problems that should be addressed in PEI process:

- Family violence.
- Substance abuse.
- Emotional disorders in children.
- Parenting, parent-child interactions.
- Discrimination against persons with mental health issues.
- Social isolation, especially of elders.

Processes of Community Engagement

Mental health intervention projects emerging from these community collaborations require:

- Time and open communication.
- Feedback to communities.
- Mechanisms to provide feedback information to counties.

Suggestions Emerging for MHSA PEI Planning Process

- Engage underserved communities in natural gathering places (e.g., ESL [English as Second Language] classes, housing assistance, social service agencies).
- Consider the role of paraprofessionals.
- Integrate mental health outreach and treatment with other health and social services.

Strengthening Our Community Input Process

- Limited time or capacity to address all the communities in the state that have specific needs.
- How can we make community engagement an integral part of ongoing policy processes?
- Outreach takes time and long-term investment in communication and building trust.
- How do we maintain relationships of trust with underserved communities over time?

In Riverside, Lilian Hernandez from Parent Institute for Quality Education (PIQE) briefly described her program, whose philosophy is that every child deserves an education. They run a nine-week program focused on helping parents to become involved in their children's education.

In Emeryville, Thomas Vang from Sacramento Lao Family Agency discussed his experiences as a health educator. There are many Hmong, Mien and Lao people in Sacramento and the state. As a health educator, he finds that people have multiple problems with housing, refugee issues, etc. These problems often overwhelm the health education role, and, as a result, Mr. Vang must help with issues of medical care, as many refugees have not had health care in two or three decades and have chronic illnesses--parasites and tuberculosis as well as mental health problems. Once they

arrive in this country, refugees do not understand the language and experience cultural shock. This is so hard for some that given the state of life in their country of origin, they want to go home. This is a sign that they are having problems. Some go to their elders. Once refugees lose their Medi-Cal benefits, they still need services, and have to wait at County Health for hours at a time. He noted that Hmong does not have a word for mental health, so they do not understand the issues. Mental health is a new system to this community. Discussing issues is therefore challenging. Refugees came to America to live a good life and contribute to their communities, but they need help.

B. Stakeholder Comments and Questions on Community Engagement

- **Stakeholder Comment:** DMH deserves congratulations for this effort to go to people who do not come to stakeholder or planning meetings. Who are the groups? Will there be more? Will there be a report about this? Is there a list of the groups?
  - **UC Davis Response (Sergio Aguilar-Gaxiola (SAG)):** This will become available. There will be a preliminary report that will address specific communities. The project has completed 23 focus groups already, and another ten are scheduled. It takes a long time to set up these groups, using the intensive methods described above. There are communities that have not participated in any stakeholder process in the past; they have not understood the value. The report will come out when the information is complete.
- **Stakeholder Comment:** Community engagement is vital. The number one barrier has been the criminal justice system. It is the first response for mental health problems. The mental health court in San Jose is a model program. The people in it are those who have been pushed toward prison. The program is voluntary. When entering the court, 80% were homeless; afterwards, 100% are housed, 68% are independent and many have reconnected with their families.
- **Stakeholder Comment:** Engagement has to be an ongoing process of communication. How will you do this? We have to learn how to reach out to the community, not just in crisis.
  - **UC Davis Response (SAG):** After identifying the communities to target, it is vital to recognize that it takes time to develop relationships and develop trust. We have to ask for help. UC Davis relies on key informants, people who are well-respected in the community. Key informants point the way to other local informants, the cultural brokers or promotores, people in the trenches. UC Davis trains the cultural brokers to interpret and conduct focus groups. These people deserve our utmost respect: they are the experts. Every action and interaction has to have as its goal the building and maintenance of trust. This has to be an ongoing process.
- **Stakeholder Comment:** The fact that DMH and MHSA are still looking at ethnic communities as target populations speaks to a definition of cultural competence that is stuck in the 1960s. It needs to evolve: people and organizers need to know about their culture. DMH and counties need to know about the culture of institutions. Think about culture of focus groups: organizers ask strangers to come together and talk

about how they feel; it makes no sense. It is important to know about the culture of the community in a broad sense.

V. General Stakeholder Comments

Stakeholders were given the opportunity throughout the meetings to submit questions and offer written feedback about any issue relating to PEI. These questions and comments are presented below:

Written Questions

Supplantation and Other Funding

- Is PEI 20% of the total MHSA funding? What will be the split between state and local funding? Do these funds remain carved out of total funds to the county across time or do they become included with the integrated plan after 2009?
- How much latitude concerning program design will be given for new and innovative interventions (best practice vs. evidence based or evidence based not listed for PEI), given that most evidence based practices focus on "conditions already in existence"?
- There is concern about closing skill centers and socialization centers in Riverside County. The centers provide life skills and socialization to many people. Peer recovery and support centers are being opened instead. How do we tell when a program is being supplanted and not just cut due to budget? If a county funds part of existing programs and adds a peer support program, would this be supplanting or enhancing existing programs?
- Many county probation departments have been told that MHSA money cannot be used for incarcerated juveniles in juvenile halls. Is this true?
- With the very short timeline to do local planning, will counties have sufficient financial resources to really engage stakeholders from other systems (education, juvenile justice) in PEI planning?
- It seems contradictory to PEI and MHSA that many counties are now refusing outpatient mental health services to the uninsured and indigent patients. These patients will cost the government somewhere else, either in the emergency rooms or jail.

Age Groups

- Can older adults be considered an underserved population?
- Can older adults be considered as "onset to serious psychiatric illness"?
- Can older adults have major input for their interventions?
- Commissioner Jerry Doyle mentioned the following statistics: 50% of people with mental illness have their onset before age 14 and 75% emerge before age 24. Can he or DMH provide references for these statistics?
- Given the events at Virginia Tech, what discussion has there been or will there be about prevention and early intervention services for transition age youth in institutions of higher education? Most colleges and universities are woefully understaffed with counseling services. Some have one counselor for 4,000 students.

As reported in the April 26, 2007 Sacramento Bee, one college said, “We have no plans to increase counseling services. There is no money.”
- Is PEI looking at housing needs of children? The housing workgroup is sending the population for respite care, however, this is not permanent housing.
- What happened to youth who are not in juvenile hall, but are on probation already and are beginning to show symptoms or signs of mental health problem? They are at risk of more serious mental health issues. Is this PEI?

Oversight
- What oversight will DMH provide, if any, to ensure that a variety of prevention efforts address the entire age span of 0–25 and especially 0–5?
- Will the MHSOAC be satisfied with a county that only dedicates the minimum of 51% of funding for 0-25 age group? Will these counties be required to justify that planning decision?
- Will selected techniques to reduce stigma and discrimination be based on research, including from other disciplines, and then be adapted for special populations? Many strategies with little evidence of success seem good to advocates.

Collaboration
- Why are community-based organizations included as partners with whom DMH is working?
- Will community clinics, such as federally qualified health centers, be able to obtain funds to provide integrated mental health services? Currently clinics cannot bill for two services delivered on the same day, which inhibits coordinated same day service.
- Dr. Aguilar’s presentation posed the question, “How can we make community engagement an integrated part of the ongoing policy process?” Will DMH’s guidance to counties and the DMH review of plans consider whether the county plans have ongoing mechanisms to involve community services and providers outside the mental health system that work with very young children (0-5) and their families?

MHSA Requirements Clarifications
- Do children have to have a diagnosis in order to receive services with the PEI funding? If not, how will DMH decide who is eligible for services?
- Is the treatment of someone’s first presentation to the mental health care system considered “early intervention” even if the person has had symptoms for years?

Written Comments

Age Groups: Young Children
- Priority populations should include specifics about 0-5.
- One county is lumping together children and youth, with the result of primary focus on the youth population and the exclusion of very young children 0-5.

- It is encouraging to see awareness of need to address parent-child interaction and maternal depression. These are critical for all children, but especially for children 0-3 in their earliest stages of development.
- Please provide guidance to County Mental Health about the importance and definition of including young children and families in the process.
- The distinction between early intervention and treatment breaks down for young children, particularly 0-3, when treatment is prevention and the need for brief vs. long-term services may not be clear.

Age Group: Children and Youth

- California's most vulnerable children and youth are not receiving the mental health care they need. Children and families often are not equipped to recognize the signs and symptoms of mental health conditions, while those who do seek care often struggle with personal, cultural, financial and transportation barriers that severely limit their access to services. The result is that 70% of children and youth do not receive the mental health services they need.
- Please do not exclude children's services from small counties. It would be another area in which children and families will not receive services or focus. The facts about the percentages are the same for these counties.
- All counties, including small counties, should be required to address children 0-25 in PEI planning. Otherwise, one of the most important periods for prevention and early intervention may not be included.
- The only children we can offer counseling to are Medi-Cal beneficiaries.

Age Groups: Youth

- In Sacramento County, there is a disconnect between Children's Mental Health and Adult Mental Health Services. Young people who turn 18 have a difficult time continuing mental health services and they often do not have the energy and understanding to go through this process, which can be complicated.
- It is important to have "youth voices" incorporated into the recommendations for requirements to the counties. The California Adolescent Health Collaborative and California School Health Centers Association are currently surveying youth throughout the state for input on how to best meet their mental health needs in a culturally competent and youth responsive way.
- Transition age youth need coping skills classes within high school to provide life skills preparation.
- At-risk youth are left behind in the school system for the sake of targeting the No Child Left Behind policies and are placed in remedial classes. Can PEI statewide efforts address this issue of meeting proficiency targets vs. youth needs?
- There are numerous evidence-based practices for preventing school failure, behavior problems, juvenile justice involvement. Place emphasis on using evidence-based practices.

Age Groups: Older Adults

- It is appalling that there is not an older adult stakeholder process or specific funding allocated to older adult services. In clinics and hospitals, it is clear that older adults

with mental illness need unique and nonexistent services. Consider this ever increasing need.
- Fund comprehensive home and community approaches to detect and treat serious mental illness, especially depression in older adults, including those who are homebound and residents in Residential Care Facilities for the Elderly (RCFEs).
- Older adults who have experienced discrimination since early childhood have been harmed by this history of trauma. What will PEI do for these seniors?
- The priority populations seem to leave out adults and older adults.
- The target population does not emphasize age groups except children and transition age youth. In regard to ongoing stigma and discrimination, the document does not mention the older adult age group which continues to be underserved. The document continues the ongoing exclusion of older adults from the planning process in PEI.
- Suicide prevention efforts should target older adults when loss is evidenced due to death of spouse. Outreach to groups with specific risks.
- Regarding older adults: older adults are 13% of the population but 19% of suicides. A third have visited their primary care providers within one month of their suicide. Primary care collaboration is important for PEI.

Incarceration/Law Enforcement/Juvenile Justice Issues

- Early intervention must include juvenile justice youth. Do not give up on mental health services to them because they broke the law. They have the ability to make great changes with successful, evidence-based mental health services that engage youth and families.
- PEI strategies to prevent incarceration should include crisis prevention warm lines that are run and staffed by clients; client/survivor-run peer advocacy groups to support clients who are at risk of or have survived negative encounters with law enforcement; client-run training programs to educate clients and help provide supports and prevent crises; client-run trainings for law enforcement; client-driven public education campaigns on how to respond to people in emotional crises in other ways besides calling 911 to prevent death, hospitalization or incarceration.
- Concerning children and youth at risk of juvenile justice involvement, perhaps the definition could include any youth involved with juvenile justice who exhibit signs of behavioral and emotional problems, thereby intervening early and preventing the development of severe emotional disturbance. Use a “no wrong door” approach.
- Early prevention and intervention has a profound impact on helping families prevent continued abuse, trauma and removal of children and youth entering the juvenile justice system. Thank you for focusing funding, planning, legislation and time on PEI.

Underserved Communities: Cultural Groups

- Why is there no break-out group for underserved ethnic and cultural groups? These are unique issues that do not figure into the other categories.
- MHSA funded programs can eliminate barriers that prevent undocumented parents from being able to access necessary services.
- There should be more mental health services for Pacific Islanders.

- Focus on racial and ethnic populations and limited English speakers.
- Planning dollars for local PEI needs should allow maximum flexibility to bring the voices of racial and ethnic groups forward as they have not been heard from.
- Families need help in the cultural transition of immigration, especially those who do not speak English. Children from these homes experience more problems at school and at home. These families should receive services through MHSA.
- Primary prevention must address slavery, immigration and historical trauma.
- DMH will never address disparities or health inequities and injustice without disrupting the current formulas for disaster, such as concentrated poverty, violence, isolation, lack of access in marginalized communities, particularly within communities of color. These are the breeding groups for illness and disease of all types, including mental illness. To provide PEI services to help support and stabilize families around the margins will be key.

Underserved Communities: African Americans

- Historical trauma in African Americans is not being treated.
- There should be more services within the African American community, who are very isolated in this meeting. Services should be for people who do not see anyone who looks like them or talks like them.
- There should be a national, state and citywide movement to train youth of color to enter the mental health field. Let's encourage young African American men to become therapists and mentors for the communities in which they were raised.

Underserved Communities: Special Populations

- Children in guardianships, kinship care and being adopted are a specialty population which requires additional training and support for professionals and families.
- Mandate a focus on foster youth. The state has a special responsibility to these children, as the agency that has taken their care and custody away from families and communities.
- The cultures of the range of consumers – of people who were formerly incarcerated and people with experience in the juvenile and criminal justice systems, of sex workers, drug users and others who survive in part through involvement in underground economies – must be included in unserved and underserved populations.
- Conduct outreach for PEI with the gay, lesbian, bisexual and transgender (GLBT) population.
- The underserved include parents with mental illness problems who do not seek help out of fear of losing their children.
- More services are needed for single mothers with children who are struggling alone. Single parents raising teenagers notice how people do not really care for others but think only of themselves or how it will benefit them. There are no Good Samaritans anymore, but a lot of hatred and sadness in the air. What is a single parent to do trying to raise her children while dealing with her own battles? Single parents need help and support.

Underserved Communities: Refugees

- Include PTSD in priority populations as many refugees and other underserved communities experience complex traumatic stress.
- Refugees are not being given proper focus and emphasis in the Santa Clara County MHSA process. They are being subsumed in certain ethnic groups, and though some of these groups include refugees, not all refugees in the county are being represented in these specific groups, nor are the common experiences of refugees as a whole receiving the specific attention they need. Needs relating to war trauma, bereavement and uprootedness are specific to refugees.

Potential Models

- Help to find funding for early childhood mental health programs that do not fit into EPSDT criteria and guidelines. There has not been a way for mental health dollars to support these important programs because they often work with systems, providers, schools, etc. It is a different model. This is the model of consultation developed by UC San Francisco and Jewish Family and Children's Services. Yet the programs often address early social-emotional issues and can have a huge prevention impact if consultants could be placed in every preschool.
- Make plans so that additional services are not layered on communities and schools. Resource Coordinating Teams should be trained in the public health model and connected with communities.
- The public health model is not included, but could be used as a model for DMH to promote. The Institute of Medicine has a classification and framework for community prevention that focuses on population. Community risk factors are left out, although they contribute to the problem.
- Move away from a medical model to a community-based culture model for treatment and prevention.
- The mental health field needs to look back to the field of sociology in the 1970s and 1980s and its research and knowledge base of community organizations and of working on a grassroots level. It will save a lot of time. The knowledge base is already there and MHSA does not have to reinvent the wheel. Funding sources have been largely dropped, but the process was effective.
- Has DMH looked at other models or agencies with proven track records of prevention and early intervention? If so, will DMH share this information with the counties?
- Use a three-tiered model: prevention includes promotion of wellness. Models are described in the Florida State University School Mental Health book provided to the MHSOAC last September.

Holistic Models

- Mental health needs to be integrated into every facet of our society, from pediatricians to schools, not remain a separate entity. There should be a seamless continuity of care from birth to death.
- PEI provides the opportunity to broaden the lens of the evolution of the mental health system to move beyond its ex post facto treatment focus and to move beyond perpetration of a "mental illness" system to a true "mental health" system designed

to foster and preserve mental health within the context of the family and the community.
- A new social contract for justice would build on indigenous wisdom integrating mind and spirit.
- Utilize integrated holistic models.
- Support indigenous systems of care.
- Build mentally healthy community based on culture and spirituality.
- Build a system that is people not data driven.
- Publicize the Life Center, a client-run wellness center in Los Angeles.

Strategies
- Provide more wraparound services to prevent need for group homes and more support to family-based caregivers.
- Provide access to after school activities and healthy outlets, including money to pay for sports participation for foster youth.
- 70% of all professionals in the state work in the cities where they graduated. Use a head hunter to promote other communities to professionals currently practicing in Los Angeles, San Francisco and San Diego.
- Create a statewide group of language providers who could be used to provide translation into all the threshold languages for program materials.
- Provide information about involvement by individuals who are both clinicians and parents of children with mental illness. Many therapists' bias of parents of these children leads to mistrust of help. People who are both a parent of children with ADHD and bi-polar disorder and autism as well as a therapist can help train clinicians to break down barriers to access.
- There is a national program that identified five strategies to combat teen violence. Are these strategies being used to develop guidelines for teen violence prevention?
- Provide a voucher so that consumers and their parents can choose their own services. Holistic services, choosing one's own providers, and family involvement show cost benefits and results.
- The best way to have an impact on mental health of children is to offer mental health and emotionally intelligent parenting to families and guardians.
- Each county would offer an array of trauma-informed services to meet a wide range of needs for people of all ages, genders, cultures and ethnicities.
- Develop strategies to address substance abuse and co-occurring disorders for those at risk as well as for those who support or care for them.
- The underserved and unserved communicate primarily by word of mouth, not email, postal mail, television, radio or newspaper.

Additional Priorities
- Given that some 50-70% of seriously or persistently mentally ill individuals are co-diagnosed as substance using, this issue should necessarily be woven into the planning process with PEI.
- Research evidences that those with serious mental illness have greater recovery outcomes if caught during the first break: less use of resources, less hospitalization, greater employment opportunities, better prognosis.

- There is a difference between early onset (children and youth) and late identification (adults and older adults).
- There needs to be more focus on promoting health and wellness and strengthening families. There should be more specific prevention activities as part of the plan or the prevention focus will be lost.
- Emphasize support of families and caregivers. Mental health reimbursement practices need to focus on coding and reimbursement policy changes for this population.
- Evidence-based practice is needed for treatment for youth adopted by way of termination of parental rights, specifically assessment and family therapy.
- Evidence-based practice is needed for pre-adoption services for families.
- Be sure counties understand that they need to fund services that support families under stress regardless of whether or not anyone in the family has a diagnosis.
- Programs that actively prevent homelessness from occurring by keeping families housed and programs that intervene early in family homelessness and assist in rehousing them rapidly should be eligible PEI activities. These programs are not currently supported by the Housing Initiative or any other component of MHSA. The Housing Initiative will not address the issue of homelessness prevention and early intervention in homelessness which should be seen as trauma-reduction and prevention. Homeless children are at high risk and will not be served well by the Housing Initiative because of its emphasis on full service partnerships and adults who are homeless.
- Data support early diagnosis and treatment of autism. This prevents larger problems later in life. Consider funding county programs addressing early diagnosis and autism treatment, as well as research into causes.
- PTSD is not widely understood. Carjackings, gangs, and the prison systems leaves people with PTSD with flashbacks and nightmares.
- Acknowledge long-term effects of the sex trade industry.

Collaboration with Schools

- Schools are the most important vehicle for PEI.
- For families that do not have the means to hire or acquire psychiatric, psychological “intervention measures” for an emotionally disturbed adolescent, the school systems need to provide an intervention program. All children deserve the right to receive freedom from serious mental or neurological disorders as well as the right to be educated academically.
- By placing prevention and early intervention services in schools, high-need children and youth can be identified early for mental health concerns and provided the services they need to reduce their risk of serious mental illness.
- Teachers and school staff are often the first to spot the signs and symptoms of mental health problems. When clinical services are available on campus, teachers and staff can refer students for on-site screening or counseling and help prevent severe mental illness.
- Every school district is developing a federally mandated wellness policy of which mental, emotion and behavioral health is one of eight areas to be addressed. These efforts segue into MHSA PEI work.

- There has been a historical tension between the educational system, including elementary education, and the mental health system about who is responsible to pay for mental health services for students. Maybe this is a project for the Innovation component: how to work with the educational system in improving and increasing collaboration so that the deplorable statistics on educational campuses can be improved.
- PEI must have a place in public schools. School psychologists and counselors are qualified, but county mental health agencies do not want to fund school-based programs.
- Money should be allocated to putting mental health services in schools.
- Mental health services need to be delivered at the schools, which are the hub of the community. Low-income and culturally diverse populations tent to mistrust mental health agencies and are fearful of the potential stigma.
- More funding should be included to help school psychologists in the schools to deal with early diagnosis for mental illness.
- More coordination between schools and outside agencies is needed once school staff identify youth with potential needs.

Collaboration with School Health Centers

- Classrooms are good places for prevention. School health centers work with teachers to teach students more about mental health.
- School health centers help schools to be more positive environments for students.
- School health centers provide families with education and resources to support their students' mental health and prevent school failure.
- School health centers provide a variety of youth-friendly services and do not look like traditional mental health clinics. This makes them more attractive, less stigmatized places for students who want to seek care.
- School health centers earn students' trust by maintaining strict client confidentiality. This makes students feel more comfortable asking for help.
- School health centers are located on campuses which makes them convenient. In many cases, having services immediately accessible makes the difference between students using services or not.
- School health centers provide mental health programs to meet the cultural, linguistic and social needs of all students.
- Research shows youth are more likely to access the mental health services offered through school health centers than those offered elsewhere. Research also shows that students who use the mental health services provided by school health centers are also more likely to attend class and less likely to be referred for disciplinary reasons.

Collaboration with Primary Health Care

- An important aspect of PEI can be a rule-out of differential medical diagnosis. Will counties be able to use MHSA dollars through PEI or any other MHSA programs to provide any level of medical evaluation or will medical services continue to be limited to referral? Note that in Los Angeles County, there is a geriatric physician in the county older adult program and a pediatrician in the juvenile court program. Their services are vital to the delivery of quality mental health evaluation and services.

The county will employ more nurse practitioners in the future. Currently this is funded through County General Funds.

- HIV is a very important co-morbidity issue. This cuts across the topics of stigma, trauma, early intervention concerning testing, medical care and mental health issues particular to HIV, such as dementia.
- Late onset depression is first break for most older adults: 48% of these older adults visit their primary care providers for help with depression while only 8% visit a psychological professional. Primary care collaboration is important.
- Regarding older adults: older adults are 13% of the population but 19% of suicides. A third have visited their primary care providers within one month of their suicide. Primary care collaboration is important for PEI.

Collaborations with Community-Based Organizations

- Include community-based organizations (CBOs) that specialize in serving individuals, families and children from underserved communities in the planning process from the very beginning.
- Make arrangements so that small CBOs that serve unserved and underserved communities are able to receive funds either directly or through partnerships with larger agencies.
- Counties should not preclude CBOs that serve unserved and underserved communities from providing PEI services due to lack of Medi-Cal certification or an inability to bill Medi-Cal. It should not be required that agencies agree to become certified to provide mental health services under Medi-Cal in order to apply for or receive an award.
- Strongly encourage traditional, larger, established organizations to establish meaningful partnerships with small CBOs that serve particular underserved communities.
- Encourage all CBOs, not just those with existing contracts with the county, to provide services under PEI-funded contracts.
- Counties should tap the expertise of small CBOs in providing training on how to work with particular underserved communities. The CBOs should be given time to provide adequate training and should be fairly compensated for these services.
- There are many substance abuse providers who have not historically been funded to serve this population, although they do serve this population through substance abuse funds. Counties should not restrict CBOs from applying for this funding.

Other County Collaborations

- PEI strategies need to be comprehensive approaches. Alcohol and drug problems contribute to mental health problems. When reviewing proposals, include alcohol and drug community experts as evaluators. Community associated alcohol and drug risk factors need to be reduced.
- Coordinate outreach with Area Agencies on Aging through AB 2920.
- Use PEI funds for collaboration with schools, primary care, county mental health, nonprofit community-based organizations, probation, etc. It is important that these entities have the time and money to meet with each other and communicate regarding children and families.

- Require coordination with social services for foster care and child abuse; primary medical care, especially pediatricians; law enforcement; school systems, including preschools; and childcare.
- The California system of higher education (community colleges, state universities and the UC system) needs to be included when developing PEI for priority populations. Onset of serious psychiatric illness occurs in the transition age youth group.
- Stresses experienced by college students are known to trigger mental illness. California colleges and universities are beginning to address the mental health needs of their students and could benefit from collaboration.
- In addition to workforce education on permanency for PEI providers, prioritize PEI contracts to current providers who are creating and supporting permanent families in foster care and probate guardianships.
- Access to mental health services by the county departments of social services is critically important to achieving child welfare objectives of permanence, safety and well-being. Too often county mental health departments have a narrow definition of qualified mental health providers. This results in lack of services needed to achieve objectives. Encourage seamless collaboration between county mental health and social services departments in development and implementation of plans.
- All after school programs should have a mental health component.
- All after school programs should have a partnership with a community center that would serve the parents of the children or youth. Alternatively, after school staff can work with the parents' mental health and family wellness issues.
- Counties should include their family resource center in planning, contracts and service delivery activities.
- PEI programs to address the risk and impact of trauma from family and domestic or relationship violence should not simply rely on existing family and domestic violence service agencies expanding their community outreach programs. The domestic violence shelter system and the mental health system have failed too many survivors by creating coercive, controlling environments that re-traumatize survivors of violence and interfere with their efforts to live independently and safely in the community.

Collaboration with State Agencies

- Have DMH coordinate with the California Department of Aging (CDA).
- DMH and the California Department of Social Services must partner to support permanency for foster youth. From the minute a child is removed, there should be an emphasis on supporting stable placements and preparing youth and families to cope with separation and reconnection, without needing to give a diagnosis or medication if inappropriate.

Client-Driven Programs

- Peer support is the link between treatment and recovery.
- People in recovery are role models for prevention.

- Mental health client/survivor-run programs are needed for diverse communities such as, but not limited to: GLBT specific ethnic populations, sex workers, people who are currently using drugs, and people who follow abstinence-based programs.
- PEI programs to support survivors of family or domestic violence should always be driven by clients and survivors of family or domestic violence. Peer-run programs are badly needed and are uniquely qualified to serve the needs of violence and trauma survivors in local communities.
- Clients/survivors should always have a leadership position, full representation and meaningful participation in campaigns to reduce discrimination and stigma. Please see the California Network for Mental Health Clients' draft document, *Proposed Principles and Implementation Recommendations for the Mental Health Services Act Prevention and Early Intervention Component,* available through the Client Network, for further details.
- Funding should be prioritized for promising client-run educational programs to reduce discrimination and stigma as well as mutual support services to address the harm caused by discrimination.
- Youth should conduct their own assessments and evaluation of programs offered at the county level. This is particularly important for populations of youth unfamiliar to local mental health agencies as GLBT youth in the Central Valley. These youth can lead the way in breaking the cultural barriers there as well as motivate communities to act and provide services. Such a process also enables youth to be better participants as they are well-prepared and able to make their voices heard in the planning and policy processes.
- Consider requiring or recommending county evaluations to include stakeholder-led processes, such as youth-led evaluations. Such processes can generate new knowledge about participant experience within the programs. Hopefully, this can lead to better programs and innovations.
- Reassess the term "crisis." The Chinese character for "crisis" defines it as opportunity in danger. The more peer outreach available, the greater the emphasis on opportunity there may be. "The tribute to learning is teaching." (Chinese proverb.)

Suicide Prevention

- Regarding suicide prevention, many health care providers disregard suicidal comments if there is not a "method and a plan." How can MHSA change this criterion, since there are many youth who attempt suicide even though they did not have a method or a plan?
- PEI policy should target policy planning that develops ethnic/race focused suicide prevention programs and specific anti-stigma programs. These programs need to find or bring diverse communities together to design the activities.
- PEI collaboration needs to include the California Department of Education (CDE). In 2005, the CDE released "Youth Suicide Prevention Guidelines for California Schools." Few school districts are aware of and/or have implemented these guidelines.
- Suicide prevention efforts should target older adults when loss is evidenced due to death of spouse. Outreach to groups with specific risks.

- Discrimination, abuse, trauma and depression are often primary causal factors in suicide.

Stigma

- Provide funding for general outreach. Presenting to community members and organizations is not "billable." Funding drives what is done and if money is not available for community activity, it will be limited. This community activity would really help to reduce stigma.
- Integrate ideas from the MHSOAC public hearing.
- State agencies should develop guidelines, approve, evaluate and oversee PEI programs and should create specific guidelines for strategies to reduce discrimination and stigma.
- Stigma is an even larger issue for the underserved and unserved.

School Staff Training

- Develop customized training for school psychologists, counselors, special education teachers and aides. This should be required as children and youth 0-18 spend time with these groups six hours daily during the school year.
- Teachers and school staff should have mandatory mental health training. School staff are frequently the instigators of meltdowns and breakdowns in children and primary contributors to children's entrance to the juvenile justice system.
- Advocate for legislation that will institute a unit of mental health/illness education into the fifth year certification training for teachers in K-12 schools. Teachers are on the front lines and could be the first identifiers. They have no training in how to recognize mental health symptoms.
- Families and community members become discouraged and disconnected based on their initial negative experiences with schools. School staff should be trained in community engagement and empowerment practices.
- School personnel are mandated to be culturally and linguistically trained.

Other Training Needs

- Provide statewide training for promotores working in local plans.
- Provide training for promotores specific to working in schools and faith-based organizations.
- Provide statewide Parent-Child Interaction Training (PCIT) training.
- It has been shown scientifically that it would be most effective and cost efficient to target children 0-5 for PEI. It should be mandated for every county and specially training to develop professionals and providers with expertise in 0-5 age group.
- Provide timely training for organization of and recruitment for planning process as well as resources to allow for in-depth input from underserved populations in the process.
- Encourage counties to reach out to and include providers of housing for special needs populations such as senior housing. These providers need training in working with persons with chronic mental illness and need to participate in local planning and dollar allocations.

- Provide psychoeducation about trauma, grief and loss for all professionals who work with foster youth.

Cultural and Linguistic Competence

- Develop a method to ensure and protect bilingual/bicultural positions in order to allow local systems to keep such positions in times of reductions.
- When the predominately white school staff tell parents of color that their children are acting out, are emotionally disturbed, are using drugs or seem like they have ADD, the parents think the school staff are simply being racist.
- Using family resource centers and family strengthening organizations gives mental health services the cultural and linguistic entrée they need to make PEI effective.
- Mental illness is not a term that translates into other languages. One-to-one interaction is needed to communicate what is meant by the term.
- It is frustrating to require clinicians working under Medi-Cal and MHSA contracts to use evidence-based practices. It is rare to find studies showing evidence-based practices successful in ethnic communities. The therapeutic relationship is always the best indicator of effective treatment as evidenced by overwhelming studies. Clients who have suffered trauma need empathy and unconditional positive regard and to be met where they are. Allow therapists under this funding to provide client-centered services. Move away from evidence-based practices and implement outcome measurement tools (i.e., client self-reports, client family reports, etc.). Provide the target populations with the appropriate culturally sensitive services they need.
- Go out into cultural communities. Do not ask them to come to you.

Native Americans

- Honor Native American elders. Give them help and support.
- Address historical trauma or major mental health needs for Native Americans.
- Fund urban Indian programs.
- Set aside special programs for Native Americans, on county, regional and state levels.
- Provide Native American grief groups.
- Cultural exposure helps to heal, including relationships with Native American elders. The youth in the Native American community need male role models.
- Being included in Native American activities meets the needs of the community. People who are older without children or without suicide ideation are not eligible for services. Include underserved Native Americans.
- We need help. Our people are dying. Our young children and our teens are killing each other. Our children are going to jail at an early age. Please reach down into the community based, grassroots organizations which provide help and support.

CSS/PEI Issues

- Children at risk for school failure and juvenile justice are covered by CSS.
- There seems to be a gap between priority populations in CSS and PEI or is PEI going to reach those who have a mental illness but are higher functioning (i.e., not homeless or incarcerated)?

- There is concern about the number of individuals who will be identified as at risk through PEI efforts and the present system's ability to provide the services they will require.

Recreation Therapy

- People who have experienced their first break, received a diagnosis and are in a psychiatric hospital, should address ongoing recreation therapy in their discharge planning. This should not be just social activities, but targeted therapy specific to the consumer's needs and issues, to increase the ability to function, reduce symptoms, provide an opportunity to learn or relearn how to live independently. With recreation therapy, consumers learn how to manage their symptoms, change negative behaviors to more positive ones. It reduces hospitalization and increases independence and job-building. She or he should start at therapist-driven activities and gradually transfer over to consumer-driven activities where the consumer decides his or her own activities with more ability and confidence.
- Have more recreation therapists on staff in all psychiatric environments including inpatient psychiatric units, board and care facilities, and institutions for mental disease (IMDs). Integrate recreation therapy staff with physicians, marriage and family therapists, social workers to collaborate and develop treatment plans. This will create more effective therapy with less duplication.
- Develop programs in recreation therapy that involve goal setting, planning, implementation, evaluations, revisions. Accountability should include certified tools to measure conditions and progress pre and post therapy.

Meeting Process

- In the stakeholders meetings, why are the people in the audience not allowed to speak without going through the DMH delegate? Treat participants the same as DMH delegates, including having tables for the participants as well as for the delegates.
- Give speakers a two minute time limit.
- Provide an opportunity to network.
- If the facilitator allows staff to respond to questions, it leaves less time for questions. Staff answers take longer than the questions and add little value.
- Flyers and printed information should let the community know about the possibility for instant interpretation at these meetings.

PEI Plan Requirements

- Reduce paperwork.
- Use common English, not jargon.
- DMH and counties need to plan for Requests for Services that are financially viable for contracted agencies.

VI. Breakout Sessions by Priority Population

Participants were asked to select two breakout sessions in the afternoon to attend and provide feedback. The groups were organized according to priority groups:

- Trauma Exposed Individuals.
- Children and Youth at Risk for School Failure.
- Suicide Prevention.
- Children and Youth in Stressed Families.
- First Onset of Psychiatric Illness.
- Children and Youth at Risk for Juvenile Justice Involvement.

Each group answered two questions. The responses from each of the sessions are combined below, by topic and question.

A. Trauma-Exposed Individuals

The MHSOAC defines this priority population as: "Those who are exposed to traumatic events or prolonged traumatic conditions, including grief, loss and isolation and are unlikely to seek help from any traditional mental health service."

As this definition implies, what constitutes a traumatic event can cover a broad area, depending on who is experiencing it:

- Traumatic events are as varied and diverse as the individuals who experience them.
- It is not the event itself that determines whether something is "traumatic" to someone, but the person's unique and individual experience of the event.
- People across the lifespan, and within all cultural and ethnic populations, may experience trauma when they survive a single catastrophic incident, or a pattern of events that threaten their physical and/or emotional sense of safety and security.
- According to the Centers for Disease Control and Prevention, the effects of experiencing traumatic stress constitute a major public health problem, with consequences of potentially severe psychological, behavioral, medical, and social dysfunction—including Post Traumatic Stress Disorder (PTSD) and other anxiety disorders—depression, and psychotic conditions, as well as injury and death.

Many experience the effects of trauma in their lives, but certain populations are at greater risk, including refugee populations, and those individuals experiencing: community, family, or sexual violence; poverty and homelessness; and extreme isolation and loss.

Question 1: In your community, what types of trauma do people experience?

Cultural and Age Discrimination

- Racially-motivated violence and gay bashing, violence to homeless people, persons of other genders, races and sexual orientation. Too much intolerance.
- Racial discrimination.
- People from diverse cultures often feel like they do not "fit in," including people who

are multicultural.
- Language barriers.
- Crime issues, especially on campuses with different ethnic groups of students.
- Native American trauma.
- There are very few culturally-sensitive services for lesbians. There is discrimination even in the Bay Area against people who are different from the norm. GLBT people need service providers who are accepting.
- Gang violence is prevalent in some neighborhoods and is often intergenerational.
- Gang issues, gang territories and the shootings.
- Please try not to talk about it just as “gang violence.” There is school violence, gun violence, turf violence, sexual violence, then there is loss of family due to violence.
- The city of Richmond has a lot of trauma. Youth cannot look beyond their narrow world to another possibility. The whole community is traumatized. They do not leave the community geographically and they do not know to fight it or overcome it.
- Gang activity starts as early as elementary school in the African American community. This combined with substance use and the overwhelming percentage of African American men who are incarcerated has a devastating effect on the community.
- Elder abuse and lack of resources for elder abuse.

Immigration and Refugee Trauma
- Those crossing the border face traumatic difficulties.
- There is a problem with “Minute Men” on the border.
- Asian American immigrant students face acculturation issues, especially adjustment issues among parents, which in turn affect their children.
- Immigration and deportation issues. This is traumatic for the Latino community, especially with separation and isolation.
- Immigrant youth experience trauma coming here, including dealing with bureaucracies.
- Intergenerational and historical trauma, especially for refugees.
- Refugee trauma: not only do refugees bring their trauma of war, torture and political harassment from their country, but also they have to adjust to a new culture and learn a new language and where to obtain help. That adds trauma on top of trauma.
- Immigrants to this country, especially undocumented immigrants, are afraid to seek help because they might be sent back. Many do not speak English or understand the system and culture. It can be traumatizing for their children, especially when their parents are deported.
- There is trauma in the Latino immigrant communities. Parents leave their children behind in Latin America. Many go all the way through Mexico to come here. That long journey is the beginning of the trauma. Once they arrive, there is the shock of language and where to go. Once they acclimate to society, they have to learn how to find a job, and worry about whether their workplace might be raided next week and they will be sent back. The children are afraid that their parents may be sent home. These circumstances can lead to domestic violence and abuse.
- Many young people are dealing with the deportation of their parents in the Fresno area.

- The Russian community is part of a larger community of first generation immigrants from Slavic countries, an invisible minority. They bring trauma from the old country with a fear of being persecuted. There is culture shock, isolation and a language barrier. They do not know anyone. There are also drug and alcohol issues that arise from this trauma.
- Refugees and immigrants, especially war refugees or immigrants, have the trauma of coming to the US and not speaking the language. They have multiple layers of trauma. If their children become involved in gangs, it adds to the trauma.
- Religious and political traumas are big issues. For example, a Muslim child coming here from Iraq still has to live with the knowledge that someone is hunting them down. Political trauma is a fear of the government and the system. That plays into terrorist trauma and gang trauma, which result from politics.
- The Native Americans who come from the southern region of Mexico only speak Mestizo and are a very tough population to serve.

Violence

- Post traumatic stress disorder (PTSD).
- Harassment and threatening someone in his or her own home.
- Robberies and muggings.
- Rape, blackmail and murder.
- Crimes against women, not only in the home.
- Teenage environments that create violence are detrimental, especially in prisons.
- Corporal punishment.
- Older adults become victims and are not able to obtain the care they need.
- Children who are exposed to traumatic scenes in the household.
- Children are too often exposed to dangerous situations, especially children whose parents are too often living under the influence. Parents' lack of awareness opens the possibility for molestation.
- Family violence, abuse and relationship violence.
- Violence, especially against children.
- Witnessing suicide of a parent as a young child.
- Children ages 0-6 witness a lot of violence; sometimes they are the victims. In some families, it is ingrained. In others, the mother is the victim of domestic violence. Many children witness it on the streets.
- In addition to witnessing domestic violence, children witness sexual assault against their mother or carjacking.

Abuse

- Family violence and family abuse. The incidence of mental illness and substance abuse is three times as high among abused families. This issue could split alliances between family members and consumers.
- The threat of abuse.
- Mental abuse.
- Among immigrant women, there is domestic violence, along with fear of these behaviors becoming the norm in their cultures.
- Some of the underlying issues in substance abuse among women include

abandonment, homelessness, domestic violence, violence and molestation.

- Sexual assault and sexual abuse are major sources of trauma within families as well as in relationships among teens and adults. There is a punitive silence enforced, especially against children who are sexually assaulted by family, caregivers, teachers or clergy.
- Abuse by a minister with no assistance or intervention from mother.
- Child abuse and neglect, particular developmental issues for children 0-5.
- Neglect: sometimes a parent is not there or a child does not have a supportive relationship in school.
- One huge area is sexual abuse of some sort, whether adults or children, and whether they directly experience it or witness it.
- Child-predator situations.

Family Issues

- Families whose hands are tied: systems break up families.
- Caregivers of family members who have Alzheimer's disease. Caregivers need care for trauma from treating family members.
- Trauma of having a child – adult or not yet an adult – with severe mental illness. The child may be homeless, and, at various times may be missing, incarcerated, or have trouble getting services. There is a constant cycling between hope and disappointment. Think about the families that undergo these long, sustained challenges.
- Trauma to family members of a mentally ill family member, feeling or being abused, exhausted, guilt-ridden, anxious, terrified, etc.
- Not all families abuse their loved ones. It can happen at times, but not to all.
- Clients who do not receive services and whose mental health issues are severe may victimize their families using financial, emotional and property means.
- Parent Effectiveness Training from 30 years ago taught that parents can discipline without spanking. Stop spanking children, especially on the bare bottom; it turns them into sadomasochists later on.
- Children who are exposed to intergenerational trauma are likely to be caught in the cycle. Mental health can learn from those working in drug and alcohol where prevention and early intervention is a separate entity from treatment.
- Young people are in trauma due to substance abuse or the loss of a parent.
- Children are the most vulnerable population and do not always know they are traumatized, but will stop going to school. Trauma is often under-recognized in children.

Foster and Adoption Issues

- Foster care children experience twice the rate of PTSD as other children as do pregnant and parenting teens. Stress can affect the health of their babies for their entire lives.
- Removal of children from their parental home. Children continue to suffer from this, even with successful reunification, with long-term effects on their ability to work. The child welfare system does not have enough services.
- Reunification that does not work out.

- Adopted children and youth, especially foster children experience the initial trauma of being in foster homes, then once they are adopted, services stop. Then at a later age, when they seek mental health services, they are retraumatized, along with their families, by the whole process. They are released from the system even though they are experiencing trauma.
- Losing a child into foster care or adoption.
- A pre-adoption that did not happen.

Loss and Grief

- Loss of spouse is a catastrophic health event.
- Death of loved ones is traumatic.
- Divorce.
- Death of one's children.
- Deaths related to substance abuse and alcoholism, either immediately or over the long-term.
- Exposure to death itself.
- The trauma of having a loved one commit suicide is significant.
- Having seen a loved one die, be killed, commit suicide, etc.

Past History

- I am a survivor of historical trauma. My family and I were sent to an Indian boarding school. Parents and children were scattered like cattle in a truck and brought to a big boarding school. One day the guardian taking care of us on a Friday night stepped out of the room when I was waiting for a shower. Children were screaming. Suddenly a nun appeared and started shaking me. Then she threw me down on marble floor and kicked me, shouting, "Get up, you savage!" I got up, whimpering. I ended up in the infirmary with an ear infection that left me deaf the rest of my life. It was horrible being separated from our families. One of the elders molested me for many years, while the priest would rape me whenever he could for years. He would laugh at me and mock me. At 12 years old, I was still on the reservation and did not want to go anywhere else to finish school. This is why I became a dysfunctional parent. I had seven children.
- Effect of childhood trauma during adult experiences of trauma. Combined with multiple traumas, many people need the support of professionals beyond a prescription.
- Untreated traumas that have never been addressed
- The lasting effects of multi-generational traumas.
- Historical trauma should be researched in terms of how it effects generations. This would include such issues as slavery, Jim Crow laws, and internment of Japanese Americans during World War II, and the Vietnam War.
- Holocaust survivors.
- Older adult women who were victims of childhood incest and experience sex abuse as older adults.

Trauma by the System

- Trauma by the mental health system.

- There is the trauma of unfulfilled expectations. The MHSA is setting consumers up to believe consumers will have their needs met. One trauma is knowing what one needs, then asking for it and being turned away.
- Forcing services on people against their will is a form of trauma. Move toward the future in which people can obtain lower levels of support earlier.
- County department of mental health and the schools declare children ineligible, even those who are self-medicating and cutting themselves. The school psychologist traumatized him.
- Do not use the term "caseload": consumers are more than cases, they are people.
- Being "5150'd" and not obtaining adequate help beyond one night is traumatizing.
- Fragmented services.
- Termination of services upon emancipation.
- Turned off by services offered.
- After a childhood of abuse, county mental health turned the consumer away, which further added to the experience of trauma.
- PEI programs to address the risk and impact of trauma from family and domestic or relationship violence should not simply rely on existing family and domestic violence service agencies expanding their community outreach programs. The domestic violence shelter system and the mental health system have failed too many survivors by creating coercive, controlling environments that re-traumatize survivors of violence and interfere with their efforts to live independently and safely in the community.
- Negative responses from those who are supposed to provide support can traumatize: intake workers, staff at supportive housing, domestic violence and homeless shelters, mental health services and therapy, physical health, institutions and systems can cause trauma. Clients and survivors need to design programs for PEI to change the dynamic of these systems to provide new alternatives to institutions.

Other Health Problems

- Receiving a clinical diagnosis.
- Trauma includes severe medical diagnosis such as cancer.
- People who are HIV positive, have PTSD, and are mentally disabled with co-morbid condition (cancer, etc.).
- There is a trauma in relation to the high incidence to HIV and co-occurring disorders.
- Co-occurring disorders and multiple treatment disorders.
- Seniors who have a sudden medical issue such as a stroke often experience lack of attention to their mental health needs.
- Persistent disabilities.
- Self-medication.

School

- School bullies. Recently, 18 year-old boys were lying in wait in a school restroom and attacked a student, choking him, with a knife to his throat. This has led to panic attacks in the classroom and beatings in the classroom.

- Bullying and bullying prevention should be addressed because the victims become victimizers and the victimizers become more prolific without treatment.
- A lot of trauma happens in school including school failure. It is important to educate teachers about the effect of school failure. Children need relationships with adults at school before they need a mental health intervention.
- Train schools to address trauma issues. There is an impact of trauma on schools, and multiple crises every day; e.g., community violence, lockdown, sudden death of a teacher or student or parent.
- Remember Maslow's Hierarchy of Needs: children need unconditional acceptance. Children are in school more waking hours than they are with their families.

Law Enforcement/Incarceration

- Those who have been incarcerated and who should have been screened for mental health issues at a younger age.
- Youth involved in the juvenile justice system are traumatized in many ways, especially sexually-exploited minors and girls who are abused and criminalized because they did not receive treatment they need and act out.
- There needs to be gender specific treatment in juvenile justice and in mental health in general, including treatment for men to reassure them that it is okay to acknowledge their emotions.
- Crimes committed for activities relating to survival, such as prostitution and drug-related crimes.
- Court systems. Families resist becoming involved in mental health services out of fear of getting caught up in court system or ending up on the street.
- Men released from prison too often cannot work because of strikes against them and cannot help their families. This can result in domestic violence in the family.

External Events Beyond One's Control

- Civil unrest.
- Environmental disasters.
- Earthquakes.
- Disasters such as 9/11 or a natural disaster is generally ignored but can take many years to overcome. Survivors have experienced physical, psychological and spiritual trauma. Survivors can lose their jobs, homes, colleagues and friends. There is the perception that the community is taken care of by others, including the corporations, etc., but that is not always the case. People are displaced and all of a sudden they do not have their community around them to support them. Focus on this, especially in the future with the inevitable large scale disaster.
- Accidents that happen.

Economic Issues

- High rate of mortgage defaults cause people to lose their homes.
- Prices of rents. People cannot find housing.
- Homelessness. Living on streets can bring various problems like sexual abuse, PTSD, other medical problems, etc.
- Poverty.

Military Experience

- The military is coming back from Iraq: there are many families in which fathers, brothers, etc., are never coming back.
- More and more soldiers are coming into the community: there will be more medical and family issues.
- Military persons come back with PTSD, which adds to stress on their families.
- Some of the people coming back from Iraq are not doing well. The military does not have money to help them. There will be thousands with PTSD.

Life Stressors

- People overlook the daily traumas. Often people obtain help for big traumas, but not for daily or chronic traumas, such as grief, feeling disenfranchised over loss of one's home or persistent disability, such as a physical or mental illness.
- Changing schools through promotion or transfer or out-of-home placements.
- Frequent moves.
- Experience with very difficult people, such as someone with multiple personalities.
- Urban communities have trauma and depression.
- Life events such as marriage, childbirth, etc.
- Verbal abuse in grocery stores and on the street.
- Loneliness.

Stigma

- The stigma of becoming a client is very traumatic.
- Discrimination.
- Consumers experience trauma in the socialization of people with mental illness: from incarceration and stigmatization in neighborhoods, especially low-income neighborhoods, where many people who have been incarcerated live. Often neighbors have the ability to obtain drugs. Then, rap music people launch a "no snitching" campaign, which sends out the wrong message to people in the community. It teaches them to look the other way when they see drug crimes.
- There is trauma from media damage, especially violence and stigma on those with a mental illness.
- Families with ADD become isolated in the community.

Strategies

- CHADD (Children and Adults with ADD) helps families with ADD.
- Arts and music help self-confidence and both sides of brain.
- Start to look at neighbors and beyond individuals. Realize MHSA cannot provide enough services to meet all the needs and begin to look at what can be done in the community.
- Instead of having a teen drop-in center that is only open until 9:00 p.m., provide 24-hour places for youth in trauma to go to, not necessarily just professional, but someone to talk to and to provide unconditional acceptance. Night is the toughest

time for those with PTSD and flashbacks. Sometimes talking to someone face-to-face is better than talking to someone on the phone.
- People need assistance to get on with their lives after trauma, and to reach wellness.

Question 2: What are the obstacles to seeking help for trauma experiences?

Systems
- Too often, children are punished for having been sexually abused rather than the perpetrators. This is a barrier to treatment, as eventually, the child will learn to stop speaking up.
- Co-occurring disorders can be a challenge to getting services.
- Point of entry substance-related discrimination reduces access to treatment.
- An obstacle experienced after a traumatic situation is bringing closure, progressing forward to the next phase, but overall, social services agencies fall short.
- Providers and systems say, “If I can take care of you between 9 and 5, and then go home, that is good.”
- Vietnam veterans still need help with trauma. It is hoped that the VA and the federal government will take care of veterans coming home now. Their families are also at risk and there is concern about whether they are and will be taken care of. They also become violence-involved, reliving experiences. Families are not recognized as experiencing trauma.
- Servicemen with PTSD and their families experiencing trauma are unable to access Veterans Administration services.
- County Department of Mental Health is not up to date. For example, women often do not want a male therapist for PTSD. Everyone should be able to access their own records, or their family member’s records. Prevent consumers and family members from being re-traumatized by the system.
- County systems do not have effective collaboration among departments.
- The mental health system is diagnosis driven.
- Depending on where one enters the system, i.e., child welfare, psychiatric emergency, drug treatment, determines the treatment a consumer receives.
- Waiting lists are too long.
- Lack of focus on prevention and intervention within the mental health system.
- Transportation, especially in rural areas.

Fear and Distrust of Bureaucratic Systems
- Families do not want their children removed and may refuse treatment, especially hospitalization, to prevent this. Families need choices.
- Victims of rape are afraid to engage in the system, due to stigma, discrimination and fear of being attacked by the same or another predator. The stress of going through the criminal justice process is substantial and the process may not result in justice in the end.
- The past experience and ongoing threat of forced treatment and hospitalization of mental health clients is the primary form of systemic discrimination that creates a

barrier to clients who are seeking support from mental health service providers. This can be remedied by transforming services to a client-driven, voluntary, self-directed model, and developing and funding alternatives to hospitalization and force that is client-driven and that supports people in emotional distress before they are in crisis.
- Past trauma of forced treatment.
- Systemic discrimination is a major obstacle. This affects seeking and accessing treatment in all areas such as domestic violence, substance abuse, etc.
- There is fear that seeking help for traumatic experiences will cause more harm than good (child welfare involvement or increased violence).
- Grandparents raising grandchildren fear losing grandchildren if they seek services.
- Board and Care homes are supposed to be safe. Some are not.
- Mistrust of government.
- Bureaucracy.

Lack of Trust

- The right questions are not asked in a caring, compassionate way on the subject. People are asked to expose very private information to strangers, and with trauma, that is the most vulnerable part of that person. How the question is asked is critical.
- It takes a long time to find someone to trust and then to learn to trust him or her. It is not just about accessibility to someone who will listen. One does not just find someone to immediately trust and talk to. Often it takes several attempts to find the right person or people who will listen, and some insurance companies are unwilling to pay for that many initial consultations.
- Some people are concerned about privacy and confidentiality and will not seek treatment as a result.
- Client-therapist confidentiality is important for any child.
- Not all children have been abused by their families. Families and parents have fear about being blamed and will often not seek help or tell the whole story.
- Issues of trust, especially for Native Americans for the dominant culture.
- Therapists blame parents too often for their children's mental health issues. This can prevent reunifications, which could improve children's lives. Look at senior family members at the same time, because the family stress may cause trauma for them as well.
- Often the person who is experiencing trauma does not know that life can be different or that she or he can admit to him or herself that she or he is traumatized.

Eligibility Issues

- People must be enrolled in Medi-Cal and qualify for services before they can be served, but that can take six months or more.
- Our system and legislation are full of "Catch-22s". For example, a client can jeopardize Medi-Cal eligibility if he gets a job, so he is discouraged from seeking employment if his treatment needs are extensive.
- Involvement with the juvenile justice system takes away access to Medi-Cal assistance.
- There is not much available for people who are not Medi-Cal beneficiaries.

- Only people with Medi-Cal eligibility can be served in the county.
- It is hard to obtain services and hard to qualify.
- Non-Medi-Cal eligible youth, especially without insurance, are unable to access services.
- A fail-first system in which people have to be seriously ill before they qualify for help.
- Restrictions on eligibility.
- The label of "seriously and persistently mentally ill" in order to obtain help. People who are less ill are not part of the target population and therefore cannot obtain services.
- Requirement for medical necessity.

Cultural and Linguistic Issues

- There is not enough recognition of what people are feeling which is a result of inadequate culturally and linguistic-appropriate services.
- There is a lack of African American men in treatment due to past PTSD for which no treatment has ever been received or even addressed.
- Cultural competency of staff is an obstacle.
- Fear of accessing services results from fear of deportation as well as cultural barriers to seeking services.
- Media and other sources for information that do not reach non-English speaking groups about getting help one on one.
- Language.
- Institutionalized racism, sexism, ageism…all the "isms"!
- Students in the schools in Richmond are not taught Black history, or so it is said. They then do not have a history, so they feel it is acceptable to use the "n" word. A lot of cultures have lost their cultural identity.
- Cultural barriers.

Older Adult Issues

- Age can be an obstacle.
- Extreme isolation with older adults is a concern.
- Elder care.

Media

- There are people on television who are very disturbing. Being in a room and feeling that sense of disturbance can prevent the building of trust.
- The media appear to exploit the presentation of people in trauma for their own purposes. This can result in people being resistant to seeking help to avoid the labels produced in the media.
- Look at trauma as it is defined. There are people who isolate from the trauma, then become re-traumatized from looking at the media showing traumatic events (e.g., six channels of police shows with dead bodies on TV).
- Social acceptance of violence in the media. Society is not traumatized quickly enough.

Dominant Culture Messages

- America's "success" image can be an obstacle. Everyone is supposed to feel good. No one is supposed to show the effects of trauma. Everyone is told to take drugs to feel better. It seems there is a pill for everything.
- Those pills are more for the bottom line of the pharmaceuticals, not the good of the patient.
- The easy habit of medicating people in need instead of taking action to reach out without medicine.

Intrapersonal Issues

- Survivor's guilt is an obstacle to treatment, especially for the GLBT.
- People do not always connect their issues with a trauma they experienced in the past. Teach the public at large about those connections, and how to get help.
- Lack of social skills can be an obstacle.
- Substance related issues must be addressed in order for programs to be effective.
- Someone who has been traumatized is often in a "fight or flight" mode, when decision-making is compromised.
- A person may be too overwhelmed to seek help.
- People do not have insight about their issues and do not pursue help or are too impaired to seek services.
- Youth sometimes feel responsible for adults' trauma.

Retraumatization

- The most vulnerable are those who have been traumatized before: those who already have symptoms are left almost unable to cope and are tremendously isolated and need to be with people one-on-one. They are the most at risk.
- The effect of multiple traumas; for example, the Virginia Tech shooting. Children and youth leave home every morning, they go to school every day and witness more, in addition to the national trauma on the news.
- Retraumatization, especially in the juvenile justice and foster care systems. The past keeps coming back to them and re-traumatizing. How can appropriate care be provided without intentionally re-traumatizing people?

Funding and Resources Issues

- There is a lack of sources to non-identified clients who need prevention or early intervention services in order to intervene before mental illness sets in.
- Lack of flexibility in funding is an obstacle to treatment.
- Funding is an obstacle; funding should be flexible to go where families are.
- Lack of funding to pay for services is an obstacle.
- Lack of affordable housing is an obstacle.
- Working women need childcare in order to obtain treatment.
- Transportation is an obstacle, especially for older adults.
- Competition for resources within the mental health community is an obstacle.
- Lack of parity between health and mental health services, especially for older adults, is an obstacle.

- There is not enough money, so mental health departments can only treat the severely mentally ill.
- Lack of resources in the mental health field and other fields.
- Lack of reimbursement for ongoing care, particularly for the uninsured.
- Lack of money to pay for services.
- It is backwards to address substance abuse issues before trauma issues, because of the lack of availability of therapy or client cannot afford to pay.
- Lack of resources for sufficient home-based services.

Lack of Providers/Caring Providers/Trained Providers

- Trauma is a very new science. It was not until 1987 that therapists first looked at trauma. Providers do not receive training or attend mandatory classes on trauma. Education is needed for providers on trauma.
- Trauma-based therapy is new. There was no clinical descriptor for trauma until 1980. The field is just looking at the differences between trauma and depression.
- There is a need for more trauma therapy specialists who are trained specifically to address trauma. DMH should require evidence-based treatments only.
- Many times, service providers do not have experience with trauma.
- Lack of knowledge on how to screen and treat properly for mental illness and substance use is an obstacle.
- Therapist caseloads are so large they create an inability to be intimate.
- Focus on young children and honor the childhood experience. For example in assessment, how is a child's trauma identified? What kind of vocabulary is used? How can the child's experience be understood? It is a huge problem in what MHSA is trying to accomplish. The DSM IV says that the child has to have experienced symptoms for six months, and a young child cannot articulate that. Rethink how clinicians know this and express it. Assessment for 0-3 is good, but reimbursement is not efficient.
- The skills of people in the system.
- There are not enough quality and qualified mental health providers.
- There are no avenues to reach out to people who may have had traumatic experiences.
- Staff need core competency and specialty training to be more effective and prepared to assist people.
- Discrimination by mental health providers.
- Lack of genuine care.

Lack of Services

- Lack of permanency for foster youth.
- Lack of outlets for healthy activities.
- Appropriate treatment and assessment.
- Lack of wraparound services.

Lack of Client-Driven Services

- Include school-based with client-driven services.
- The lack of availability of peer-to-peer support, to help deal with the fear of getting

into the system is an obstacle.

Lack of Family Support

- A major obstacle is when there is no buy-in from families and partner.
- Family discrimination is an obstacle. If a person is isolated in his or her home, he or she cannot access services.
- If child is not taken care of, child welfare should be brought in, or else the next generation will go through the same thing their parents did.

Denial

- In years past, abuse was not considered abnormal. It was done to a person who then did it to others. When there was pedophilia, the secret was kept within the family. Even now, not every parent understands that they are harming their child, "That's the way I was raised," and they raise their children the same way.
- Denial.
- An acceptance of the trauma as being normal. For example, a grandparent in a grandparent support group was concerned that his teen grandson was not alarmed at the violence they had witnessed.

Stigma

- The shame and stigma experienced by young children who are assaulted causes the problem to continue. Such children often cannot articulate their feelings and providers who do not know how to help may prescribe pills with no support. All this can combine to result in a total break-up between people's need for and receiving appropriate services.
- Stigma is a huge issue for parents who are blamed.
- Fear and shame.
- Stigma, especially around those with HIV, is an obstacle. This might be overcome by sensitivity, risk reduction or anything having to do with the reduction of stigma.
- Discrimination is an obstacle.
- Stigma and fear of being labeled "crazy."
- Stigma of seeking mental health services.
- Fear of legal consequences.
- Embarrassment.
- Tendency to blame the victim.
- The onus is on the individual rather than the institution. If there is historical disenfranchisement, there is no reason to want to change one's life.
- Employment can be an obstacle: there may be limited time off, work itself can be stressful, and it may not be in one's best interested to speak to one's employer about one's personal or family situation.

Schools

- Schools are often not mental health friendly. Children generally must fail first to qualify for services and SSI.
- School bullies are obstacles to treatment. Children in early education need safe places.

- Teachers do not know how to identify trauma although they do welcome information on trauma, as this is something they deal with every day. They do not know what to do or how to ask questions, and therefore do not address it. Every weekend something happens to a student, but their teachers do not know how to deal with it. Provide education and identification of resources.
- The growing lack of school nurses means teachers must recognize trauma on their own and know how to use appropriate language in talking to a student or co-worker.
- Schools undermine AB 3632 entitlement by refusing to refer.

Homelessness

- Prevent trauma from occurring by preventing homelessness. Work with families who are about to lose their housing. This will prevent certain trauma.
- Address trauma that is certain to happen: homeless shelters are by definition traumatic settings. They have massive, concentrated numbers of people with issues, uprooted children, etc. Shelters rarely have access to clinical or mental health services and the mental health system does not see shelters as their responsibility, despite the fact that shelters are the front line of service to people facing homelessness.
- Programs to prevent homelessness should focus on preventing the factors that lead to homelessness: discrimination, domestic violence, lack of planning upon release from jails and hospitals.
- Provide continuation services to youth emancipating from foster care so they do not become homeless.

Need for Education

- Sometimes people do not understand what is happening to them.
- Lack of information.
- Lack of education on the nature of the trauma.
- Not enough understanding of collaborating with CBOs.
- Little understanding of how the developmental age level of a person when the trauma occurred affects treatment.
- Misconception and misunderstanding of mental health “disorders.”
- Lack of knowledge about the mental health provider.

Education Solutions

- Provide client-driven trainings.
- Educate and provide ongoing treatment for students to address symptoms.
- Educate teachers to identify trauma in students.
- Provide mental health professionals with training that is specifically focused on trauma. Not enough professionals know how to treat trauma.
- Provide education and psycho-education on effects of trauma, problem-solving and treatments that work.
- Teachers can educate students about mental health strategies to promote healing and build resilience.
- Teachers can avoid adding to their students’ trauma by not projecting negative thoughts, behaviors, and symptoms such as triggers.

- Educate teachers, parents, grandparents, siblings, caregivers, special education staff and school administrators.
- Develop trauma education for students and parents.
- Provide trauma education for administrators, including how it can impact students' chances of graduating, etc.
- Police need better training to identify mental health symptoms.
- Not having awareness of the ways people can heal and finding the key that can unlock that door. Creative and expressive arts therapy can be very helpful. Make different resources available and let people know that each person heals in different ways.
- Give consumers tools to handle themselves.
- Implement public or community education about trauma.
- There are so many misperceptions about mental health.

Directions for Solutions

- Identify and treat trauma in a holistic way.
- Work to change the culture of how families react to their loved ones.
- Empower those who have been traumatized to make decisions for themselves.
- Focus more on client-driven services, as written in MHSA.
- For children and youth, provide more family-driven services.
- Multi-lingual and multi-cultural staff are needed in schools.
- Need culturally appropriate trauma resources and multiple programs. People heal in different ways, such as creative and expressive arts.
- Develop outcome measures for all programs that include areas of substance intervention, screening and treatment.
- Address self-care issues for mental health professionals to decrease burn-out and people leaving the profession.
- Some safety net prevention and early intervention services must take place in public schools with school staff.
- There is a lot of research about mental health and DNA. There is a lot of hope with research on brain development. Cognitive therapy, journaling and modeling all have an impact on brain development. All of this goes a long way beyond just giving pills.
- Reduce drug abuse in families.
- DMH needs a policy that emphasizes identification of the person traumatized, through screening and assessment tools that are expanded to schools and pediatrician offices.
- Nonprofit and community-based organizations are integral to a holistic model of healing.
- Consider prenatal substance abuse as a fetal insult or trauma and to look at prenatal services to help birthmother to decrease use of substances to numb her own issues and unresolved traumas.
- Move from "fail first" to "serve first."
- Treat the actual problem.

Specific Solutions

- Eye Movement Desensitization and Reprocessing (EMDR) by a trained provider can

help overcoming trauma. Obtaining good services is critically important, as is self-awareness.
- Transitional services are needed for people coming out of prisons. Expand AB 2034 for prisoners. The path to homelessness is one of steady isolation, because former prisoners cannot obtain services. Their isolation needs to be understood. Society should stop criminalizing the mentally ill. Hold both the individual and system accountable and get them out of jail and prison.
- A conservatorship can help shut-ins. Change laws about conservatorship.
- More therapy and more appropriate therapy are needed for trauma. Disseminate treatment models to therapists.
- Probation in Monterey County is about to start screening every youth who comes through the system as early as possible. The chances for success increase the more screening is done. Many of our youth live in a war zone.
- Provide a range of types of services. Some people like traditional therapy, while others cannot access help by talking to someone without similar experiences.
- Include people in the development of their treatment plans, especially adolescents.
- Develop services to enable foster youth to participate in “normal” activities such as after school programs, sports, dance classes, art and music.
- Open services to their friends who may have similar experiences but are not foster youth.
- People with trauma should be encouraged to share their trauma experience with groups. That is the beginning of recovery.
- Offer more groups for people addressing different types of traumas.

Other
- Lack of a conceptual imagination.
- Caregiver and helper trauma can lead to burnout and eventual psychiatric breakdown.
- Environmental injustice.
- Instability.

B. Children and Youth at Risk for School Failure

The MHSOAC defines this priority population as children and youth with unaddressed emotional and behavioral problems who are at risk of school failure.

- Children with serious emotional disturbances have the highest rates of school failure.
- 50% of these students drop out of high school, compared to 30% of all students with disabilities.
- Four out of five children who need mental health services do not receive them. Those who do are often served through schools.
- Children are usually referred for screening or identified as having mental health needs as the result of behavior problems in schools.

- In schools, counselors work with both academic and emotional issues and are overwhelmed with the number students they are assigned.
- In 2004–2005, California had a student to school counselor ratio of 906:1 (CDE CBEDS, 2004), nearly the worst in the nation.
- Prevention and early intervention efforts targeted to children, youth, and their families can improve school readiness, health status, and academic achievement and significantly reduce school failure.

Question 1: In your community, what types of programs and services work best for children and youth who are at risk of school failure due to behavioral and emotional problems?

Specific Programs by Name

- Dr. Mel Levine's All Kinds of Minds programs work in schools. The program is strength-based and teaches about brain differences so that children understand why people are different.
- Many mentoring programs prove to be powerful, for example the Big Brothers and Big Sisters program. The Department of Education grants for these programs have resulted in behavioral improvements.
- The Bridges Program in Los Angeles is a program that involves parents and helps comfort them. It works to make schools more responsive and creates friendlier environments especially for communities of color. Specifics include basic system changes that make it easier for school personnel to communicate. Schools too often do not understand about confidentiality, which is essential when it comes to mental health.
- Cityscape uses art such as poetry and music and works with both children who are identified and not-identified as needing mental health services.
- Bruce Anderson with Community Builders in Washington helps children and youth with emotional behavioral problems and offers in-school skills builders. It helps schools and students to be more welcoming.
- The Early Mental Health Initiative (EMHI) funded by First 5 and opened up to K-3 students is a stellar program. It is available to all schools and districts in the state. It is unfortunate that the program is limited to these ages and is only three years long. It has research-based programs and is school-based, low-cost and supervised by mental health professionals. A community collaborative assists with program implementation for children with mild to moderate adjustment problems in schools. It serves those who normally might not receive services because they are not severely ill. The legislature continues to fund it despite other cuts. EMHI requires that school districts have mental health services and there is a support system built into this program. Its programs involve paraprofessionals are working one on one with children.
- The non-profit provider EMQ Children and Family Services in San Jose provides intensive transition services for teachers who do not have resources at school. Teachers can call for consultation to avoid student expulsion from school.
- Healthy Play, while expensive for schools, teaches violence and bullying prevention.

- The Healthy Start model is an excellent model to build upon with PEI funding.
- NAMI has a program that is being piloted in Orange County: Parents and Teachers as Allies. It has been successful, but the challenge is getting the school to allot the time necessary for it. Reaching schools is not easy. If teachers want a program, the administration does not want to give time for it. Key ingredients to the program are giving teachers the family and client perspective, knowledge offered in a booklet, and guest speakers who share their experiences with mental illness.
- NIMH has a school curriculum that is aligned with standards.
- Nurtured Heart Approach, a program developed by Howard Glaser is a strength-based approach that gets to the heart of developing resilience. This was used with parents and therapists but was not as well received by the education community. Schools in Arizona used this program where it significantly improved test scores while the number of children and youth on medications decreased. Immediate results can be found at www.difficultchild.com for acting out behaviors.
- Parent Partners for Tri-City Mental Health is a wonderful link. It provides information in order to know what the community has to offer. Many did not know about special education in schools. There is a community agent to interact with the county mental health department, and the program has mental health professionals who are there to help consumers access services they need in the community.
- Peace Builders teaches children to treat each other well. This program praises children.
- Positive Behavioral Interventions and Supports (PBIS) is a national model that provides promotion and wellness. Traditionally used in public schools, PBIS helps to improve behaviors. It is modeled after a program in Chicago where it works to catch youth early on in schools, before they fail or are expelled. Several schools in Los Angeles have probation officers stationed at schools. Referrals come through Probation, but mental health needs have not been identified. Probation Officers can help in providing linkages.
- Positive Results is based in nonpublic schools.
- Santa Clara's First 5 Preschool for All program prepares children to enter the school system.
- Rosemary Children's Services Program is a school-based program for identified foster youth that uses in-class incentives, peer counseling and a health component.
- The National Center for Mental Health Promotion and Youth Violence Center has five or six sites in California for Safe Kids and Healthy Schools, of which Pomona is one. All are research-based, but not limited to curriculum. Schools alone are not the answer, just as mental health alone is not the answer.
- Second-Step violence prevention program is used in preschools. The parent education component helps bring the community together.
- Sonoma - Social Advocates for Youth program is effective.
- The Village-Student Assistance Program (SAPS) is collaboration between the Department of Social Services (DSS), Probation, and Education, all of which are next door to each other. Professionals teach teachers and staff. Children go to groups with peers and professionals.
- Student assistance programs where youth are referred to a core team of administrators, teachers etc. SAP sets up support groups. North Carolina has some

groups geared toward substance abuse. The model has been adapted for many ages as well.
- World of Differences, a program by the Anti-Defamation League; Community of Caring, a school climate values-based program; and EMHI provide services through a school-based mental health professional to low and moderately high risk student with mild issues.

Specific Programs by Location

- Amanecer has a school-based program with therapists who are at schools.
- Benicia has prevention programs. Primary Intervention Program (PIP) is a relationship-based program. A paraprofessional works with the child and builds relationship with him or her. Second Step is a universal classroom program but also has pullouts if one on one meetings are needed.
- Benicia Youth Action Taskforce consists of 15 organizations sending individuals, council members, faith-based representatives and others to talk about services that are needed and those being provided to spread the word and fill gaps in services.
- Berkeley children's mental health has bridged the gap with the school district. An agreement was signed between Berkeley Mental Health and schools for a school mental health plan. This is a partnership to jointly fund mental health coordinators, and family advocates to be at every school.
- Campbell has Positive Behavioral Interventions and Supports (PBIS), EMQ Children and Family Services and school-based treatment services.
- Carpinteria Cares for Youth has been effective. It also has a section called START.
- Chico Unified School District has an EMHI, which provides services to children in K-3 through grant funding. Many districts pick up costs after three year grant ends. School wide programs, recently preschools are doing Second Step training that is also being applied for older children. Alternative education programs are doing a good job for children and youth at risk of failure. This program used to be a continuation high school methodology. Now there are different levels of interventions and more individual attention can be given outside of class. There is a specific component for children and youth expelled due to violence or drug use.
- Chino has proactive activities focused on youth. Their program provides counseling, social services, etc. It includes an intern counseling program.
- West Contra Costa Unified School District has a school health center providing school based service along with youth-based service. Some activities include spoken word for youth with incarcerated family members and survivors of trauma. There is synergy between mental health and youth development.
- Contra Costa Mental Health recently established a school-based partnership with CBOs that direct services toward particular ethnic groups in community. Five CBOs are targeting Asian/Pacific Islander, African American, and Latino communities. Communities trust their community agencies. Services may be traditional but the partnerships between schools and CBOs are important to create the sense of collaboration.
- West Contra Costa County school-based models are collaborative. They work with ten to twelve CBOs that provide services to students. Promote collaborative models.

- Fresno County started a community team where clinicians would go out to home, school, etc. They are flexible in order to see those who have stopped attending or moved.
- Los Angeles Unified School District (LAUSD) has a model in schools where there is a Ready for School and a First 5 center attached to an elementary school with Healthy Start. The school district partners with the mental health agency and families receive services before problems develop. Parents who are in programs that are not mental health based, such as Mommy and Me are included. If they know people who work for these programs or people who have participated, they are more willing to get screening because it reduces stigma.
- Community Partners in Los Angeles County go to classes and offer counseling. One middle school is currently implementing this program. The goal would be to get into elementary schools. It is important to let teachers know that the program, Valley Trauma Center, is available.
- Los Angeles County Children's Services has Casey Families Program, a collaborative program to enhance school stability for children in out-of-home care, to help children obtain better outcomes. When children are moved to foster care, it takes time to adjust. The pilot site also has an Ambassadors Program for any child who is new to schools. The program holds meetings with principals and teachers and involved staff. While it started as a give and take relationship, social workers now receive report cards from schools. In the Student Study Team (SST) process, the social worker is identified as crucial part of the child's education and is invited to attend meetings with the child.
- Los Angeles does community building outside of school-based mental health. Efforts include organizing families around their children's school, promoting parent organizing and building empowerment through parent-run initiatives. Community-based organizations often help support these efforts. County units in Los Angeles that are involved in these efforts include the library and children's councils.
- Pasadena Police Athletics League helps children and youth at risk by changing their ideas about law enforcement.
- Pomona received a $9 million grant for Safe Schools Healthy Students. Six months later schools have an intervention specialist. The contact is Patty Acevedo.
- Riverside had a Safe Schools Healthy Student grant.
- Programs to create connections between children and adults are important, such as instance the at-risk program for Asian youth in Sacramento.
- The San Bernardino County Public Defender has 9-12 week parent education classes that are helpful.
- San Francisco has an early childhood mental health consultation for those working with young children. This has been in existence for seven years.
- San Francisco has a wellness initiative to reduce disparities. There are eleven comprehensive sites called wellness centers where there is education to students, educators, administration to, create a healthy, friendly environment in schools and increase access by providing services on site. There are fewer barriers to services.
- In Ventura County, Clínica del Camino Real is the only provider serving community schools. There is a need for expansion of these services.

- There are a number of school health centers throughout the Bay Area. School administrators can look to them for resources when they need services for youth.
- There is an intern counselor program operating in Southern California, with 40 interns with students from all over the region, funded on a shoestring. Each intern has 20 clients and the program has only one supervisor. None of the interns are paid, so in terms of cost benefit, this program is very effective. A wide range of students are served.
- Adolescent counseling services in Palo Alto unified school district run groups on campuses. Students see their peers participating in activities and it decreases stigmatization.
- North Valley School has a way to provide support to students with mental health issues. Students sometimes return to class with little treatment. Children move back and forth from public to non-public schools. In-school services and in-home family programs are often more effective.

Program Ideas to Help Children and Parents

- Friendship circles can help young people with emotional behavioral challenges who do poorly because they are ostracized. The circles involve teaming the young people with children without these challenges.
- Parents in one community organized to create a music program for students. Children have become more active through the arts.
- Family advocates help to access services and refer families to appropriate places.
- Research talks about family systems to raise children and youth. These involve the community, using a holistic approach.
- Bring in effective parenting programs.
- Parents go to schools first because they do not know where else to go. Parents need to have a place of support for the family.
- Intensive family support services are needed that are an effort to try to position children and offer opportunities to learn. Special Start is a program for children who are graduates of neo-natal care and are entering at-risk environments. It teaches parenting skills to normalize developmental projectiles.

Programs and Services in the Schools

- Use the public health model to address the issues of dropouts. If a student fails the 9th grade, he or she is more likely to drop out of school. How many enter 9th grade with a failing average? There is a high correlation between these students and families receiving Medi-cal.
- Start sooner, before kindergarten, as the preschool movement picks up mental health consultation for providers to understand how to interact with children. Children are appearing with behavioral problems early. So much is known about brain development. Over half of children will be in preschool settings before they reach kindergarten. Child care providers are asking for this support.
- Mental health consultation and assistance to preschool sites should be available.
- By putting services at school, they become part of the institution and there is a better understanding as opposed to being disconnected. It is immediate if services are needed right then.

- Evaluate all children on the first day of school to make the screening and assessment more holistic and user friendly.
- Implement procedures in schools for children with difficulties. There are interdisciplinary meetings where students are referred to counseling at any age. Because some programs are in place, it is possible to refer to community mental health. Children and youth can go to private sources or to special education. School-based clinics would help as well as more services provided in schools.
- Support schools around implementation of PBIS models. This would help teachers help their children.
- Offer classes for students who have been sent to tight disciplinary settings that are not conducive to their mental health. Different people experience problems differently and need various options. There are other ways to address various kinds of violence.
- Schools need skills builders to remind children and youth of what expectations are. Early intervention is needed, especially with children and youth starting to show behavioral challenges and difficulty.
- School-based services are essential. Schools are where students often feel comfortable and where they spend their time.
- School health centers are an important provider of health and mental health services for children and their families. They are available throughout the state and many provide mental health services.
- School health centers can identify children and youth at early stages and prevent them from moving on to the next level. Children and youth with insurance use school health centers who normally would not receive services.
- Onsite mental health support for adolescents and school health centers should be widely available.
- Provide more classes in special education for people who cannot read or write. They need computer skills too.
- There needs to be more education in schools. It can be challenging to identify children in need of help. Schools refuse to go to the Individualized Education Plan (IEP) process because they are afraid of having to provide services. Better collaboration is needed so they are not afraid to identify students. Many schools have School Attendance Review Boards (SARBs), but these are often accusatory and negative. School-based programs are not ideal for all students; they open up doors and then close them when they return to class. Intense therapy without time for regrouping afterwards is not safe.
- At-risk behaviors are first identified in the school system. Teachers do not have resources.
- An effective educational program to prevent school failure includes certificated early childhood teacher; lunch; eight students to each adult; parent education and participation; support services; development of self-esteem, decision-making skills and critical thinking skills; math, reading, writing readiness curriculum; and oral language and English language development. These will result in the following outcomes: grades improvement, skills improvement, socializing, moral values learned at school apply at home, self-esteem

- Offer unstructured, open classroom schools, which would provide access to training in lab sciences. Lab sciences offer low risk opportunities to work in a situation that could be transferred into the workplace and provide job skills.
- A World of Difference program is very important to help reduce discrimination in schools.

Program Ideas for Collaboration

- DMH should consider a comprehensive approach that collaborates with existing programs on interventions. Prevention programs can prevent onset. Schools are overpopulated, with no chairs, or books: the environment can be depressing. Poverty also contributes to depression and suicidal thoughts. DMH should incorporate the public health model, which considers not only individuals but also the environment. For example, there are limited areas to play in communities: what are the effects of this?
- It is not one agency; it is a collaborative effort across agencies that is important.
- Partnerships among education, law/probation, mental health, and social services are needed. Involving families is essential to addressing school failure. An important element of addressing this population is to select the target groups. It is not about diagnosis. Have a plan to follow and have someone mentoring children. There are programs that have evidence basis for all grades.
- Another support system in communities is the CBOs that work with children and youth, for example, ESL classes and community activities. The challenge is that the school system is not comfortable with outsiders coming onto campuses. Do not just reach out to parents who will come to campus; work with CBOs where the parents who are not comfortable at school do feel comfortable.
- Try to develop a partnership with the local YMCAs and incorporate programs for mental health advocacy. Many students of color do not feel comfortable on the school campus.
- Structures in effect right now should couple connection to mental health and other areas of developmental support and assistance.
- A report in Los Angeles about reducing gang activity sent a clear message that any approach has to be comprehensive in order to make an impact.

Program Ideas to Target Professionals

- Institute a mandatory class on social emotional issues and behaviors for teachers. Develop collaborative with mental health agencies, law enforcement, etc.
- Target directors of special education, because they know who to go to and how. Target people who are responsible in the district. Grades K, 1 and 2 need interventions.
- Train faculty and develop mentoring programs. For example, focus on 8th graders by matching them with older peers.
- Teachers are the first to identify issues for children such as stress, stigmatization, family issues, etc. but teachers do not have Pupil Personnel Service Credentials (PPSC) at the employee level. Teachers can identify but have no resource or contact person to connect the family to services. Help to increase PPSCs in schools.

The Primary Intervention Program has served 10,000 children K-3 by making sure to connect them to resources before problems escalate.

- For long-term process improvement, change recruitment for Masters level and include a mental health component that creates Universal Learning Support Teams. Undo the model to target high risk youth.

Programs to Reduce Stigma

- Cultural issues put individuals at risk for school failure. This has to do with cultural differences between students and mainstream society, teacher, faculty and staff. GLBT student groups and clubs in high schools are positive sources of support for students. This combats homophobia from students and staff. Similar programs are needed for students who have differences that they may be bullied about. Anti-bullying for faculty and students in general should be addressed. Rather than taking aside individual bullies, school-wide approaches about bullying are important.
- Schools are one of the first places to identify a child who does not fit in. They are often the first place to reduce stigma. It is important to bring children and youth together to let them talk so that they can share issues and not feel alone. This can happen in school or out of school.
- Remember the children and youth who were in special education classes. They were made fun of at times; this is still happening today. Some children and youth feel embarrassed and ashamed to walk into a part of the campus that makes them feel different (e.g. special education classes). For the children and youth who feel this way, off campus services are important alternatives to help reduce stigma. The schools should contribute to offer some of these off-site services for their students.

Service Gaps

- Early Mental Health Initiative (EMHI) screens every child so the program identifies the high risk children, but once they are identified, there are few services available for them.
- For mild to moderately at-risk children and youth, schools are a safe environment for interventions. In order for children and youth to access mental health services through the county or school district, they must first be identified. Schools can help at the prevention stage, while it is still primarily in the classroom. However, schools do not have to identify them.
- Some are quick to diagnose young children with behavioral problems without finding out what is going on in the family or addressing cultural issues. Nutrition is also important. There are many things that should be considered prior to diagnosis. This is a best practice: focus on it with PEI.
- If children and youth do not receive services in school, then they might not receive services at all. Often people do not seek services until they have reached a crisis.
- In Los Angeles, some schools are terrible. The schools have failed children with bipolar disorder. There are good programs in other states, but people do not want to send their children away. Where are such programs in California? It sounds like there are many programs in Santa Barbara but not in Los Angeles. Many young children there are expelled from school. Help children so that they do not end up in prison.

- All the programs discussed already exist somewhere in the Los Angeles Unified School District (LAUSD). Many of these use entrepreneurial grant funds and therefore are limited. While there are many examples of programs, there is no systemic way to implement them systemwide. MHSA will hopefully allow LAUSD to look at systemwide approaches. When students are referred, they are less likely to seek services than if they can receive services at school.
- Head Start and Early Head Start integrate and collaborate on services. However, only a small percentage of children qualify and there is no system to do this in other day care situations. Who works with the other day care and preschool sites? Who helps them understand other resources and meeting their needs? The Head Start model for early childhood helps outreach to others.
- Fifty percent of children and youth of color are not succeeding in schools. They do not have home support. Parents do not feel comfortable on campuses. Parents do not want to access services on campus.
- Fieldtrips and activities that recognize a child's strengths are not available. If there is a lack of trust, it is difficult to work with children.
- Schools have programs after hours; some areas have buses to take children and youth home while others do not. If parents do not drive, the children cannot stay to participate. Provide funding for transportation.
- Language is a barrier. Many times students do not complete homework. Many immigrants do not have an education and are not literate in their native language. Children therefore cannot ask parents for help. Provide funding to educate parents about the school system.
- Teacher, staff and parent training is needed to develop common language about problem solving.
- There is a need for peer support groups of all kinds for children.

Question 2: What specific improvements would you like to see in schools to better address the emotional and behavioral health of children and youth?

Programs by Name

- Use Asset-Based Community Development (ABCD) Institute's asset mapping and community building and development model. The onus of this type of effort is on schools, but communities can go through this process to explore the need to support families and children and youth.
- Washington State's Community Partnership Teams have been shown to be helpful. The teams are put together by the county and include family, representatives from school, physicians, and mental health professionals. This helps professionals gain perspective and provides the opportunity to better understand the child's environment. Creating and maintaining partnerships should be universal.
- Use the EMHI model, which offers intervention to low to moderately at-risk students; it uses school-based mental health professionals supervising paraprofessionals; and partners with a mental health agency.
- EMHI is not *the* answer because it is limited, but if it were combined with other programs, it would be possible to provide an array of services. EMHI covers all the

areas discussed: services are often disconnected; three or four people may see one child. One of the counselor's key roles is to assist in easing this process. Elementary school counselors can play a role in providing cohesion of services.

- Teach schools to foster a strength-based testing and IEP system, especially in the concept of a child/family team. Kaleidoscope in Washington and Comprehensive team programs are good models of this.
- School wide training for all staff in PBIS is essential. If the program is not implemented systemwide, one person at school, most likely the counselor, will know why child is behaving a certain way but others will not, which will break down the support system.
- Expose teachers and parents to similar concepts in parenting so that everyone uses the same language to describe behavior and appropriate interventions. Staff are often young and have no parenting experience. More universal curricula, more common language and common approaches are needed such as the Triple P (Positive Parenting Program) program.
- Response to Intervention (RTI) is a positive model for intervening prior to special education.
- Use Second Step curriculum at LAUSD. It has a position of a coach who provides support for model schools implementing Second Step. This program is just one piece of the comprehensive plan.
- The California Department of Education should embrace comprehensive education on mental disorders. Use the Columbia University Teen Screen Program. This is a research based program and can be used as early as 6th grade. It is not a school administered program. It is universal, primary prevention because it assesses everybody not just the ones with problems and screens periodically for different things. San Francisco is using this program in private high schools.
- Teen Screen in Orange County has served a high school in Irvine. From this beginning, it may be able to grow, because it allows schools or agencies to identify students at risk, while it educates students themselves. Youth are responsive and it is an effective tool to get rid of stigma. Some students then can identify friends who might need services.

Provide Family Supports

- Be sensitive to the circumstances within families: parents have to work to keep the roof overhead and provide food, but counties and schools expect them to be available to attend daytime meetings. Be aware that people who live on or right above a welfare check do not have the luxury of taking time off work to go to school when there is a crisis.
- It is challenging to attend IEP meetings and hear all the negatives about one's children. It does not feel collaborative and is difficult for parents.
- Children who have been suspended already have difficulty going to school. Participating in a SARB is generally a punitive experience for parents and children. More interventions are needed at the school-based level.
- In Carpinteria, there is a large immigrant population as well as concerns about gangs and methamphetamine use.

- NAMI parents do not like the label of emotionally disturbed. Children and youth may have emotional issues but they are not disturbed.
- Provide more case/care managers to provide services to families. Parents do not know how to navigate the system and this is essential to get through red tape.

Provide Appropriate Student Supports

- Start early with services in kindergarten. Focus on children younger than school age. Mental health consultation is a good way to do this.
- Do not label students. See their abilities as learners and do not look just at failing grades and assume they have a problem.
- Take advantage of the middle school years. As children transform into adolescents and middle schoolers, they move from schools with one teacher who knows them and then must prepare for the sometimes difficult transition to high school. Middle school may be the best place to reach children with emotional or behavioral issues, while they are young enough to accept help but old enough to take information and help themselves. It is also the time when parents least understand children and their needs, and children receive a lot of misdirection. High schools receive youth who are not ready for high school. Autism is being identified for the first time in high school, which raises questions about the effectiveness of early identification programs.
- Alternative schools and classrooms are important because not every child will be successful in a classroom of thirty students.
- Institute vocational programs that teach real life skills. By the time youth with mental health concerns are the age to attend community college, they have often dropped out. There has been more focus on testing and less on skill development and strengthening. Personal development class is critical.
- Youth in high schools are often moved from school to school until they end up in county continuation schools. PEI should work to provide support for these youth.
- Provide more alternatives because many children do not fit into the existing molds.
- Nobody addresses bullying, which results in children protecting themselves by arming themselves. Aggression becomes the label but the root issues are not addressed. No one asks: Why is the student aggressive?
- School-based health clinics provide important support services.
- No matter what amount of training teachers receive, children's diagnoses will not change. A mindset change is needed in dealing with children. A child with bipolar disorder was suspended seven times in one semester and expulsion would have been next. Reduce class size so that children can stay in school. Hire and train more qualified teachers for this population, and develop different ways to intervene. Do not leave these children behind.
- Reinforce teaching of children from the beginning. Teach children and youth about their own mental health. It is possible to teach resilience.
- Timing and assessment skills are important when working with children and families. Children are like cups. If they do not receive the right combination of services or receive too many, the cup overflows. Some children cannot make use of the services because they are not ready to receive them. If services do not work, people become frustrated.

Staff Training

- Provide teacher trainings on awareness and mental health facts such as half of all adults with a mental health diagnosis began exhibiting signs of illness at a young age.
- Train staff in K-12 programs to recognize signs of mental illness and work with community. This has great potential for broad impact.
- State colleges need to include training in mental health in their credential programs.
- Provide more teacher training in college or in continuing education. Teachers of a boy who was hyperactive and had trouble focusing automatically suggested that he be put on medication. There needs to be another way to assess children.
- While teachers need more training, community mental health also needs to know how to communicate with school staff.
- More staff to be educated and trained to recognize who should be assessed.
- California teachers have a fifth year for certification. Push for a component in this fifth year about mental illness. This will be a political issue, but the California public schools lost 50% of teachers by Year 5 because they are not prepared to address students' needs. How do we get this in legislation?
- Concentrate on training the mental health community and clinicians to know that services are not about treatment but about prevention. Early intervention is important to connection, prevention and treatment. Educate the community about mental health. The goal is not to diagnose.

Transform Schools

- There is no one single program nor a specific collection of programs for all schools to use. Look at different strategies and ideas, for example those with a community focus and cultural competence. Then find models for these issues that will provide a starting point for counties. Virtually all (98%) children are in educational environments; this is where they need to receive services. DMH should reach out to its education partners.
- Educational systems need to look at processes such as student study teams; these should not wait until children are suspended or expelled. School district concerns about the costs involved in early intervention, which could lead to an IEP and special education, prevent action. The education system needs to be convinced that it will save money later if it provides prevention programs earlier. Identify models that have worked and provide them to education partners. This is an opportunity for collaboration.
- Enhance communication between school officials and students. Children are talked down to about negative behaviors but are never told how to improve. Labeling of troubled youth is internalized at schools.
- Community faith-based private schools should be involved in helping with school failures. They tend to label and not help children with education. If disabilities are found, the child is expelled immediately with no family assistance.
- Provide earlier assessment for students. Start in preschool not 4th grade.
- Provide organized systems for all children, including universal strategies for referrals and treatment that reach populations in meaningful ways. There should be no wrong door.

- Study the concept of in-school skill builders and out of school skill builders. Children need repetition and reinforcement of concepts at home and in school. Parents must be involved and brought into the conversation of what is being taught in the school setting. Institutionalize the prevention of behavioral and emotional issues that people have.
- Provide more education in schools about mental health, not illness. MHSA is on the right track; PEI will incorporate schools well.
- Strengthen leadership in schools, CDE, and DMH. There are great programs but politics get in the way. Make the child and family the highest priority. Collaboration means getting together with parents, educators and administration.
- Look at the youth who are not in schools. How do MHSA and CDE come together to address this issue?
- Change of school climate is important. Schools need to work closely with support services and teaching. Suspending children and youth does not help them.
- Convince school administrators about the importance of mental health: without this, nothing is possible.
- From middle school on, it is important to solicit youth input about what works for them.
- Focus on outreach to parents. School districts throughout California struggle with obtaining parental involvement.

Specific Techniques and Programs

- Play therapy, music therapy and art therapy bring parents and children together.
- School health centers can be a mechanism of mental health services delivery because they provide access for students, confidentiality and are youth friendly. There are currently 146 school health centers in California.
- Use harm reduction for meeting people where they are. Offer more services that go out into the home or community where parents are or work with CBOs to make it easier for parents and guardians to be involved in the child's health.
- Consider the bullying program from the committee for children in Washington.
- Provide anti-bullying programs to make campuses healthier environments.
- Direct more dedicated funding that focuses on emotional and behavioral health.

Enhance Cultural Competence

- Cultural competence is essential as schools clarify how best to assess how their students are learning. Many schools use educational models relevant to Kansas in the 1950s. There is little if any evaluation of strategies that would work on the populations being served today in California.
- Offer more cultural programs after school, such as Native American cultural programs, to decrease the dropout rate.
- Institutional racism has a profound effect on children. Where a person is from defines his or her reality. People are still told they are not college material and that designates where they end up. Society will pay the price for doing this as the demographics change.

- Disproportionate numbers of children of color are not identified as having learning disabilities.
- Little attention is paid to teachers' cultural competence; there is a deficit in terms of role models. A school in Calexico has five teachers who use children's life experiences to help them learn reading and writing and were able to improve standards. The rest of the teachers were hostile to them for changing the status quo.
- California teachers are required to be trained in cultural issues.
- Enhance cultural competence: if a teacher or provider cannot talk to a parent, it does not matter how great the services are.
- Cultural competency is essential, connect with families and talk with them effectively and appropriately. Hire more multicultural school staff. Do not send letters home; call parents to ensure messages are delivered. Remember language barriers exist for many families.

Address Stigma

- GLBT youth have high chances of school failure so programs that target diversity training and acceptance are needed. Make it school policy that discrimination is not tolerated so that school is safe place.
- More inclusion and less stigmatization of children at risk is important. When children are in trouble, they are not able to participate in social activities, which further isolates them. They act out inappropriately to build safety zones.
- Learning disabilities are often identified before mental health issues within IEPs, which further stigmatizes children and families. This does not acknowledge the positive strengths of children while it emphasizes the negative.

Provide Programs for Children with Special Needs

- Children and youth with learning disabilities and mental health issues need arts programs.
- A kindergartener has been to three schools so far. The only way she can qualify for services is through an IEP. When behaviors are too hard to manage, children are put on home study for which a teacher is supposed to come to the home once a week. However, this often takes months to arrange because of the lack of professionals in this field. Meanwhile, the student stays at home without school, which leads to isolation.
- Evaluation processes in schools for admittance to special education program need improvement. Someone may be a good educational psychologist but be unable to detect emotional problems. It is important to train psychologists as well.

Collaborations

- Schools are not set up to have relationships with various agencies providing mental health support services. MHSA must create and support these systems. In a few states and counties, there is a proposed resource coordinating team that requires training for schools, and works on a public health model, which also requires information dissemination. Putting money into the systems development is very important.

- The value of collaborations cannot be overstated. San Diego County has a truancy intervention program where schools contract with Probation. Officers work at schools and participate in SARBs. The school district works to develop partnerships. Think beyond normal partnerships. Empower parents to advocate at local meetings to create programs that intervene at prevention level. San Diego wants to develop a systemic approach to develop hubs that can address many needs.
- DMH should collaborate with CDE around prevention.
- Use MHSA dollars for training of superintendents and schools on MHSA so that they know the language. Increase collaboration between CDE and DMH.
- Create a circular relationship between all components. There is a great opportunity to lay the groundwork for change.
- Many people expressed concern about children not receiving services. There are two competing systems. Children in the medical model have a DSM IV diagnosis. In education, the model follows the Individuals with Disabilities Education Act (IDEA), whose criteria are different from DSM IV. In this model, there must be three limiting conditions for a child to be diagnosed with an emotional disturbance. These models contradict each other. The two systems have to come together.
- Develop a common language between mental health and school system. Sometimes a mental health problem looks like a developmental problem. There needs to be lobbying around education code reforms that include behavioral problems.
- Foster greater community involvement instead of reliance only on administrative decisions. In the past, one county decided that all CBOs' contracts have to be selected through a Request for Proposals (RFP) process every three years. These decisions are made by best price, as opposed to the providers that work best. Integrated systems are essential for success. Word the requirements so that those receiving money have guidance to disperse funding. This will prevent programs from becoming solely county-run.
- Key people are needed; programs do not have to end when funding ends if strong collaboratives have been developed.

Leverage Current Resources

- All children and youth need support in schools and not all are related to behavioral health. Many programs already exist. Do not use PEI for services that already exist but for new and innovative programs. Use PEI funds to leverage other resources.
- There are many good programs out there so they need to be expanded. Not having funding is a result of budgetary process. Create a way to keep programs longer. Address sustainability.
- Programs that are funded for two to three years lose funding. Look at programs that can be sustained, especially ones that use best practices. If the county is not collaborating with agencies that have these programs, no changes will happen.
- Expand services that are functioning in the counties. Look at prevention services in the early stages. Middle school, high school services should be pushed to the earlier end of the spectrum. Include the whole family and build components to treat the family.
- Require that counties send the majority of the MHSA money away from the county. The county has created numerous programs with First 5 money. If the MHSA

process will send money to the county, then it must communicate that the county has to share this funding. County directed programs are the only ones being currently funded.
- There is a lack of integration and need for partnerships. Can MHSA look at allocating funds for proven community processes? If these funds are allocated, it will encourage collaboration and sustainability.

Increase the Amount of Services and Staff

- Every school should have a family resource center. Parents could go there for information. In Maslow's hierarchy of needs, children are at the bottom with survival skills when they need to be at the top excelling.
- Recruit and train counselors to close the counselor-to-student ratio mentioned earlier. More psychiatrists are needed in adolescent care. The Achieving the Promise program highlights Teen Screen, which requires parental consent, but is successful in preventing early onset.
- Fund more mental health services at schools. Mandate service access and delivery, or at least minimal case management. Finding providers is challenging.
- Without adequate funding, there are only limited roles for social workers in schools.
- Start with the children and youth who are suspended as a target population. Money is an issue as well. Families need help. Assign an advocate to help families deal with this process and recommend actions for family. Some children need one-on-one, and would do better in private schools. More programs for these children and youth are needed so that families do not have to move.
- What about the college age group 18-25? A *Sacramento Bee* article about mental health says there are no counselors and no money for this group. Can the junior college through university population be a priority?

Treatment Issues

- Children who live in residential programs receive services but those who live at home do not. Intensive day treatment services are limited and need to be increased to do prevention. Foster children and youth are doing poorly in schools. There has been some progress in this area, but more is needed.
- If a child is eligible for AB 2726 services, has Medi-Cal and receives psychiatrist services for medication with Medi-Cal, can the child receive additional funded therapy services outside AB 2726 services? How can this be improved? We have been told there can be no duplication of services, even if the child is eligible.
- Is there a mechanism through MHSA that triggers "at risk" for school failure after a student is denied AB 2726 eligibility? Does this trigger any lower intensity services?

C. Suicide Prevention

Suicide describes the voluntary and intentional taking of one's own life. Nothing about suicide is simple, even its definition. Suicide extends into all age groups addressed by the MHSA and is highly prevalent among many individuals traditionally underserved by the mental health system. Suicide is a serious public health problem with extensive

short- and long-term health consequences. The following statistics illustrate its prevalence:

- Suicide remains one of the leading causes of death globally and locally.
- Worldwide, suicide ranks as the thirteenth leading cause of death (World Health Organization, 2002).
- According to the Department of Health and Human Services, someone commits suicide every 17 minutes.
- In 2002, 31,655 Americans took their own lives.
- In California, suicide is the tenth leading cause of death (Lau, 2004).

Question 1: In your community, what activities, programs and services would be helpful to prevent suicide?

Offer Community Education

- Educate the public.
- Raise awareness issues about symptomology.
- Offer more educational opportunities.
- Fund and air public service announcements and other forms of public education.
- Provide enhanced information about the efforts to reach others.
- Offer education about risk factors and how to respond to suicide attempts.
- Offer education about fallout when it occurs: secondary contact issues.
- Provide awareness education of specific cultural issues that affect specific cultures.
- Tailor strategies to address each group in the community.
- Increase awareness and education about restriction of means to commit suicide.
- There is a lack of awareness about suicide prevention among parents.
- Media should not glorify suicide events.

Older Adults

- Older adults need services at all levels.
- Address the needs of the seniors; funding is limited in this area.
- Devote more funding to address needs of the older adult population.
- There is a gap in services for older adults in Alameda County: 20% of suicides are committed by people age 65 and older and the 60 and older population will double.
- Increase community-based services outreach approach, with outreach to churches, and to older adults who are homebound.
- Provide mobile outreach to older adults.
- Co-locate counselors in senior centers.
- Primary care providers are not the best professionals to target older adults, who go to their primary care physicians one time per year.

Offer Programs in Schools

- Offer proactive school suicide prevention.
- Talk to children in school.
- Distribute laminated information cards to schools and youth groups. These cards should provide prevention information, signs and support links.

- Educate school age children. All children in schools should receive education about mental health.
- Provide mental health education in high schools.
- Involve school community service hours to train students of risk factors of suicide. Be proactive and offer education incentives.
- Provide more clinical staff in school settings.
- Implement the Columbia University Teen Screen program in all schools. However, the screening should not be administered by the school.

Offer Peer Led Services

- Develop a new position of Peer Support Specialist used for mobile crisis supports.
- Fund peer programs like Teen Helpline in Lake Elsinore.
- Establish more peer programs.
- Friends could save other friends.
- Implement peer supportive services as early identifiers.
- Develop age appropriate strategies, which include support from people or peers of the same age group.
- Offer GLBT youth-led training and education as well as speakers bureaus for providers, educators, family members, etc. Empower those who are most seriously at risk.

Expand Prevention Efforts and Staffing

- Expand current efforts.
- Provide sustained funding to suicide prevention programs so the suicide prevention units can expand and have a stable revenue source.
- Establish mobile crisis systems to go to clients when in need.
- Hire triage persons specifically for suicidal thoughts.
- Develop programs for people who have attempted suicide previously.
- Staff warm lines for all age groups. Pay warm line workers rather than rely on volunteers.
- Train Meals on Wheels staff to identify, refer and report about risks to their clients.
- Offer follow-up in aftercare that is supportive and positive for the family and the individual who has attempted suicide.
- There is a lack of services for children and young adults.
- Develop consistency across counties as to how to address the issues of suicide.
- Establish a suicide prevention council in every county.

Provide Professional Training

- Provide law enforcement (police) additional training in crisis intervention. Use training funds for training in crisis intervention as a collaborative effort between mental health and law enforcement so no one entity has to absorb the full cost.
- Provide more training to police about crisis intervention and the effects of 5150 status. Train them to work effectively with family members.
- Distribute responder cards for grieving resources for providers who have contact with suicide to provide links immediately.
- Provide training to physicians to screen for suicide prevention.

- Make suicide prevention training mandatory as a professional development requirement for teachers, physicians, clinicians and others in the health, mental health and education fields.
- Provide training and information about what teachers could do, so that they are equipped to provide immediate service at school and incorporate strategies about suicide prevention into school strategic plans.
- Use the World Health Organization's (WHO) education materials and concepts to educate health care providers about restricting access to such means as guns.

Address Stigma

- Offer community education about suicide to erase stigma about suicide.
- Conduct anti-stigma campaigns.
- Provide education of illness very early on in the process to alleviate stigma and also to foster recognition.
- Increase awareness among the community that mental illness is like any disease such as heart, liver or cancer problems. This will reduce stigma and increase the success rate of treating any mental illness.
- Replicate or expand Riverside County Anti-Stigma conference.

Offer Immediate Services

- Offer immediate service by care providers, rather than voice message lines, so ideations are taken seriously and immediately.
- Assure suicide crisis lines in every county are staffed by live people.
- Offer immediate emergency assistance, such as ambulance or fire trucks.
- Offer immediate assistance of a counselor.
- Dispatch mobile crisis units for people who call the suicide hotlines.

Integrate Suicide Prevention into Other Programs

- Integrate suicide prevention strategies and training into primary care.
- Weave suicide prevention into an integrated health promotion campaign so stigma issues are diminished. Be proactive rather than reactive.
- Work with health plans to integrate mental health treatment with health care.
- There should be no separation between mental health and physical health.
- Nurse practitioners should be more involved with those who are homebound and provide case management.

Develop Trust

- Suicide prevention education must be provided by a trusted source.
- Maintain privacy and respect the rights of people with mental illness.
- Respect cultural values.
- Talk seriously with survivors of sexual assault, alcoholism and anorexia. These can be subliminal symptoms of serious problems.

Use Evidence-Based Practices and Monitoring

- Adopt the national strategy for Suicide Prevention and the California Strategy for Suicide Prevention: a tool published by government for use in communities.

- Provide surveillance, such as a team to study the problem to learn from case studies of suicide incidence. Team members could include coroners, law professionals, and mental health providers. Suicide Death Review Teams, were used in Los Angeles County for Under 18 suicide incidence. Expand these teams to the adult population.

Question 2: What suicide prevention strategies work best for specific age and cultural groups?

School and College Interventions

- Develop a systematic process with multiple systems to address and bring attention to the problem. Collaborate with public health, schools and others to educate about suicide and its prevalence.
- Have schools integrate supports already in place in the community before addressing the issue themselves. Schools do not currently have the resources to deal with the issue adequately.
- Do not use more clinicians in school. This will increase stigma and discrimination because of labeling issues.
- There should be supportive services in colleges and universities. DMH should work with universities on steps that universities should take.
- The higher education system needs to be partners with the mental health system, rather than writing educational papers and studies.
- Offer mental health education among young college students.

Expand Prevention Efforts and Staffing

- Use a mental health staff as a partner with Meals-On-Wheels staff. The person could ride along and be able to provide follow-up without being intrusive.
- Focus on the intervention part of preventing suicide: educate non-mental health professionals using a tiered approach.
- Educate physicians to instill awareness about mixing of prescriptions with alcohol.
- Use a gatekeeper approach.

Cultural Competence

- Conduct stigma reduction training for all ethnic groups.
- Respect language and culture issues.
- Utilize community leaders to access people in ethnic communities.
- Build a foundation of trust in communities before discussing suicide issues.
- Outreach to specific ethnic communities.
- Know the stigmas specific to individual cultural groups and use that information to target outreach and education effectively within those groups.
- Address disparity issues.
- Fund and air public services announcements that address specific cultures and age groups.
- Provide someone who speaks the same language of the person in need.
- Create specific strategies that address problems of different Asian groups by ethnicity and age.

- Include the clan elder and community leader to help the Hmong community.
- Study the Hmong Men and Women Circle from Minnesota, in order to combat the high rate of suicide among Hmong females.
- Within the Vietnamese communities, larger families have communal responsibility. Encourage faith-based interventions that address family issues in the Vietnamese community.
- For the African American community, send social workers to gathering places such as beauty shops and churches.
- In African American communities, educate the faith-based communities about mental illness and techniques that do not preach religious doctrine.

Age Competence

- Parents need to learn how to communicate with their children about trauma and its negative effects.
- Educate about young people who are sex workers to address the specific needs for that population.
- Ensure support groups in retirement homes. Fund and encourage support communities such as the Depression and Bipolar Support Alliance (DBSA).
- Collaborate with primary care providers, especially for older adults.
- Older adults are not trustful of mental health workers. Mental health staff need to be careful about trust issues among the older adults.
- When older adults suffer the loss of a spouse, they suffer depression, loneliness and isolation. Explore health technology for geographically large communities. Implement virtual senior centers or other virtual means of social interaction.
- Integrate the senior IMPACT model into primary care settings. This integrates suicide and stigma prevention in the primary care center.
- Provide additional resources for primary care providers, to work toward the integration of behavioral and mental health services among older adults.

High Risk Groups

- Because of expectations of veterans and law enforcement to stay in control and keep problems to themselves, there has been an increase of suicide rate among veterans and law enforcement officers.
- After the Vietnam War, more men committed suicide in the US.
- The state should pressure the federal government to set up programs for veterans and college students. This will support students and veterans and reduce the suicide rate in colleges.
- Among college students, suicide is the second leading cause of death.

Gender Sensitive Services

- Suicide prevention should address gender.
- Design programs that focus on women.
- Target teen mothers for prevention efforts.
- Use primary care to address post-partum depression.

Support Groups and Services

- Develop more Suicide Prevention Resource Centers.
- Offer informal non-mental health groups or social support.
- Solution Focus Therapy strengthens resiliency among young people through support and facilitated focus groups.
- Implement Youth Developmental Assets.
- Teach people how to use technology without substituting social interaction.
- Columbia University study about suicide reported the need for a support system for the family after someone committed suicide. There is blame among families because they did not see signs of depression when son attempted suicide.
- Recognize students' stress level and provide supportive services that assist them when they need counseling due to financial, academic, and family and other pressures. Teach them methods to handle stress.

Peer Programs

- Train and educate teens to "tell" on friends.
- Create mandatory high school and grade school classes taught by peers who have gone through suicide that provides information and resources.
- Support peer mentoring in small group settings in schools.
- Develop peer campaigns for adolescents.
- Hold GLBT peer support groups as a means to normalize behaviors of GLBT and decrease isolation.

Community Education and Stigma Reduction

- Increase community-based meeting strategies to reduce suicide.
- Provide early education about mental illness. Address stigma in those classes.
- Society is too judgmental; therefore there is stigma.
- Address shame and lack of understanding regarding suicide.
- Hold more open discussions in the community about suicide, depression and mental health.
- People need to know about available resources.
- Provide awareness education about common risks for specific target populations.
- Fund billboards to advertise the national suicide prevention numbers 1-800-SUICIDE and 1-800-273-TALK. Route calls to local suicide prevention centers that are able to intervene in a crisis in any of 123 languages.

Improve Data Collection and Assessment

- Improve data. Suicide events are not recorded as suicide. Coroners should do a better job at identifying suicide cases.
- DMH should develop standardized criteria for county coroners when determining cause or means of death and should then collect statistics.
- Assess recently released county jail population for depression.
- Assess the homeless population to assist with adjustment once they are housed.

Structural Barriers

- Address transportation issues.
- Arrange transportation to treatment and social events to decrease isolation.

- Medi-Cal does not pay for visits for mental health and physical health the same day; however, it does pay for visits to dentist and primary care. Resolve this problem.

Models

- The NAMI Parent and Teachers as Allies used in Hemet is a model program. In Minnesota, the course is mandatory for teachers to inform them of suicide risks and signs.
- Encourage collaboration among high school and college providers of services to transition age youth. Provide support through developmental stages. One model is the Educator Suicide Prevention Network (ESPN) in Los Angeles County.
- Riverside County's Anti-Stigma conference for high school students covers several social arenas, suicide among them. It is a daylong conference for which the schools currently pay for transportation. Other counties can use it as a model.

D. Children and Youth in Stressed Families

The MHSOAC defines this priority population as children and youth whose parental circumstances place children at risk of behavioral and emotional problems. These may be parents identified with mental illness, serious health conditions, substance abuse, domestic violence, incarceration, or child neglect or abuse.

This priority population focuses on children and youth, because the conditions of families greatly affect the children and youth. The family members are a secondary target. This means that PEI programs would include families in supporting the children and youth and may refer parents for other services. But the PEI programs are not expected to directly resolve all of the parents' problems or conditions.

The challenge of this priority population is that

- it is broadly defined;
- many children and youth are in stressed families;
- and other systems and organizations have a role in supporting these families.

Question 1: What can be done to reduce the risk of mental health problems in children living in stressed families?

Barriers

- Inconsistency in funding leaves families unsure about whether to participate in a program that may disappear.
- Stressed families do not need the additional stress of trying to negotiate funding streams as well as determine which program supports their particular need.
- In Los Angeles County, huge numbers of small children who have been detained are being screened and referred into the system.
- Agencies do not share information with each other due to policies between each agency.

- Schools should take better precautions separating children from their families by calling Child Protective Services (CPS). Schools should try to see when children are having problems and try to fix the problems rather than remove children from their families. Removal for neglect or abuse can lead to a family cycle of foster care that might have been prevented through earlier and more family intensive services.
- Children who experience severe trauma, such as a young boy who witnessed his father killing his mother, need intervention whether or not the child is eligible for Medi-Cal. In this child's situation, he was sent to live with family members who gave him a puppy, whom he killed. Because the child did not qualify for Medi-Cal, no mental health services were available, which is unconscionable.
- A continuum of services is very important: some children need light and some need intensive intervention. School-based interventions are not generally intensive. Families should have the opportunity to access services early because parents are not likely to seek them.
- Parents do not know where to go to find information. There is a lack of communication between mental health services and schools.
- The mental health system has a perception that any child with a mental health problem has bad parents. This perception affects the tone of the discussion between the system and the family of a child with mental illness.
- There is a lot of judgment within the system of families experiencing domestic violence and substance abuse. Professionals need to approach these families without judgment and to coordinate efforts on the system end.
- Different communities within the greater Asian community have different needs and issues. Different Asian communities transition differently into American society. The Chinese community has been here a long time, but there are still many new immigrants. Young people help their parents in translation. The Pacific Islander community is underserved and has few resources. It is impossible to find trained staff from that community. Look at the primary psychosocial stressors for families for each community, using a nuanced approach that can identify triggers for high risk behaviors. Certain communities do not have a concept of mental illness. For example, the Filipino community believes in a hot and cold concept that affects a person's body and mind.
- Most children living in stressed families also are at risk for involvement with crime and drugs.
- Stressed families may receive some kind of services: substance abuse treatment, medical, etc. PEI activities have to be implemented well because families can easily become defensiveness. Stressed families include people in high conflict divorces, people with life-threatening illnesses, refugees who experience war trauma. While their parents may receive some services, often the children are not considered. Educate people who provide medical services to parents with cancer and other life-threatening diseases to encourage them to ask about the children.
- Provide services, including support groups, after hours and on weekends for parents who work.
- When a child needs help, it should not require a piece of paper claiming guardianship to request assistance.
- Access to services should not be dependent on a DSM IV diagnosis.

- Change the criteria of DSM IV, especially in terms of prevention.
- There are parity issues around Medi-Cal and EPSDT eligibility. A family whose income is just above the Medi-Cal eligibility or is ineligible for Medi-Cal cannot receive services.
- Children are served through First 5 and Medi-Cal, but this is a limited fund. HMOs have some services, but it is limited also.

Stressors

- Young widows raising young children are an underserved group. They have lost half their income, have become single parents and have often lost their married friends. All these combine to create great stress.
- Veterans are in stressed families.
- Grandparents raising their grandchildren experience stress.
- Children in families with domestic violence need care.
- If the child is expelled from preschool more than once, the family is probably under stress.
- Families come to school looking for mental health support. The underserved population, e.g., low income, culturally diverse families, distrust the system. A student who had suicidal ideation was going to commit suicide to relieve the financial stress of a family in which the father had a stroke.

Partnerships and Points of Entry

- Some environmental and societal issues have a great effect on children. Stress and trauma are experiences within families facing such issues as drugs and gang activity geared to recruitment of young children. Partner with criminal justice.
- Mental health and substance abuse agencies must work together. Substance abuse agencies that work with women who are incarcerated or on parole and their children will lose funding if SB 1453 is passed. This would also affect children. Parents need these programs.
- Partner with faith-based organizations and provide them with education. Churches pilot a program between mental health services and peer counseling.
- Churches can provide family services with sufficient resources but are not sure how to handle mental health issues.
- Homeless shelters are excellent places for mental health agencies to partner with.
- Provide more funding for Head Start's mental health efforts. Many people think that Head Start has a lot of funding for mental health or even a lot of funding. This is not the reality.
- Provide educational support services in pediatrician offices. The first place stress shows up is often at the doctor's office.
- As families move through the system, there is a stoppage of services, which is evidence of a lack of trust across systems. Help provide a seamless system for families.
- Benicia Youth Action Task Force is comprised of the Chief of Police, City Council members, school board members, school superintendent and family resource center staff. The group talks about the needs in the community and the services and successfully funds good programs that work for the community.

- Partner with portals of entry where families are coming in such as Children and Family Services. This is an opportunity to engage with families before they enter the court system.
- All child care could be point of entry.
- Explore how professionals connect with families: other systems, as family resource centers and agencies not specific to disabilities. Where is the point of entry to families for peer and parent to parent support? Consider some requirement for collaboration with those entities.
- Allow counties to provide services to infants and toddlers. It may not be beneficial for mental health clinics to open a case for a child, due to stigma issues. Look at the differences among infants, toddlers, preschoolers, and older children.

Partner with Schools

- Partner with school districts to make them aware of local programs. Communication is extremely important. If schools do not know programs are available, this decreases the likelihood they will be accessed.
- How many programs do we already have in the schools? Revisit existing programs.
- Partner with schools, agencies, community resources, churches or wherever children are.
- Partner with schools to recognize the signs of mental illness. A young man who was suspended seven times in middle school and drank throughout high school was never approached by school staff about what was happening in his life.
- Schools are the most practical starting point. Require that county mental health have a resource team working with schools. This is the only way to move services into the schools.
- Another risk factor is violence in the schools. In Oakland, it is safer for a child to skip school than to attend. Having services in schools is part of the answer, but will miss those children who do not feel they are safe enough to attend regularly.

Partner with Family Resource Centers

- Family resource centers serve their community. If a family has a higher level of need, there are resources for them at the family resource center. Staff are cautious to make sure there is no stigma attached. In addition to meeting high level needs, the centers provide milk and cookies and referrals for violin lessons.
- Co-locate schools, school health centers and family resource centers. Provide infrastructure.
- Family resource centers can provide resources to reduce stress in the home, such as mentoring, peer to peer support and linkage with the schools that can connect with community resource centers.

Early Identification and Referral

- Postpartum and perinatal disorders are not always diagnosed. However, they can be screened for and parental support can be provided to both the mother and the father. Children whose parents are seriously mentally ill face a very difficult situation.
- In incidences of domestic violence, there should always be follow-up with an assessment.

- Identify stress early. Schools may observe children acting out in schools but do not always share their observations.
- Figure out how to identify families in stress. On a one shot basis, provide help to a family to identify what is happening and what can be done. When children start school, ask parents to come in to meet with teachers and friends to help if needed.
- Provide assessment before entering the school system. Once children have entered the schools, the schools usually do not consider assessment until third grade or so. This forces a child to fail first.
- Because of family stress due to immigration, a father committed suicide. Peers heard about something, but no one referred the family for any services. Share referral information.
- The word “referral” varies, sometimes it means a phone number, and sometimes it is handholding and physically taking people where they need to go.

Assessment Tools

- Is there an assessment for stressed families that is used universally? How do providers identify families that have stressors to be able to intervene mildly and help them off the path?
  - **DMH Response (EN):** There are some tools such as the Parent-Child Interaction Therapy (PCIT) assessment tool for early childhood.
- Family resource centers use a family development matrix.
- At ISOJI in Marin County, a multidisciplinary team does an assessment with a family functioning chart, which ranges from crisis to at-risk to stable to self-sufficient, addressing many issues. Referrals come from all sources within the team.

Family Involvement

- Children’s mental health issues impact families and cause stress.
- When families are stressed, they become isolated.
- Sometimes family therapy should not be optional, in order to protect the children.
- Ask the families what they need, listen to their responses and prioritize accordingly.
- Listening to families contrasts with evidenced-based practices.
- Educate families in the community about mental illness and how to properly raise their children. Our society breeds dysfunction. Until communities and families realize what they do to children, their impact will not be lessened.
- Take a family systems approach. Children are not raised by themselves. Parents need to be served as well as their children.
- Relatives must be considered, including aunts, uncles and other family members who have an impact on children’s lives and need support.
- Consider children who are acting as the parent, even children only two years older than their siblings. A family systems approach is important.
- There is a moment of shock when a parent first finds out that a child has a mental health problem that requires assistance. At that moment and in an ongoing way, families need to build relationships that support continuity, to prevent jumping from one agency to another so that as much as possible, a family only deals with one person in one agency.

- Families are afraid to obtain services because of the power professionals have over them when they are identified. Parents are afraid their children will be removed.
- Provide resources and best practices for reaching and engaging parents.
- Provide formalized parent education programs offered statewide. Every parent should receive knowledge about childrearing and this practice should become socially accepted, as sex education is now in high schools.

Training

- Educate staff in schools to cut down on stigma for children and parents. Staff should be trained, as more sensitivity is needed. One school demanded that a child with mental health issues do grade-level appropriate work, which was too demanding for the child, which added stress.
- There is a lack of trained mental health professionals. Alma Family Services has trained professionals to work with families.
- Fill the gaps in services to children. Train paraprofessionals, such as parents. Clinicians do not always have time or ability to bridge the gap. There is a huge shortage and demand to find parents. Parents feel isolated when receiving mental health care and they have no one, trained or otherwise, to talk to.
- Provide training to the staff at the point of entry to services. Systematic training for the people at the front desk will allow them to better serve people in need.
- Train promotores in mental health to work wherever children are, e.g., in the schools, clinics, Boys and Girls Clubs, to help them develop coping skills.
- A model educational program should include the following: certificated early childhood teacher; lunch included; eight students to each adult; parent education; parent participation; support services; development of self-esteem; decision-making skills; critical thinking skills; math, reading, writing readiness curriculum; oral language development, English language development. This will lead to grades improvement; skills improvement; socializing; moral values learned at school applies at home; self-esteem.

Reduce Stressors

- Catastrophic events preparation can help reduce stress by making sure family members have and understand an emergency plan. On the other hand, such preparation can raise stress levels about disasters such as fires and earthquakes.
- To reduce stress from effects of domestic violence, the three areas to identify children and reduce risk the most are 1) the pediatrician's office, 2) universal preschool, and 3) schools. Children, ages 3-5, are quite vulnerable as their brains are developing. Schools are where most children are present.
- High achiever students may fall apart if they get less than A+. They do not show traditional signs but still are at risk.
- In Orange County, youth in foster care are being moved from placement to placement, under a constant threat of "being there too long." Every move for the child creates additional trauma. Mental health professionals know what the children need, but other systems fight their recommendations.

- Many stressed families are isolated either geographically or socially. This isolation is a huge predictor of negative outcomes. Home visiting with peer visitors is really important. Bring the services to the families.
- Many mothers who are undocumented have maternal depression but are not eligible for EPSDT services. Mothers need services to help the child.
- Every county should have a program so that a family experiencing stress (welfare, refugee issues) would know where to go for services or a referral. These programs should have a visible presence and build networks with as many entry points as possible.

Meet Basic Needs

- Healthy Communities, Stronger Families, Stronger Children deploys services targeted at core needs, leveraging mental health service money to address poverty and unemployment. A Los Angeles court made a commitment to address all these needs.
- Pregnancy to Parenthood in Marin, part of the Family Services Agency, has a parent aide program that provides help with parenting and with day-to-day basic needs.
- Families in stress sometimes just need some in-home practical support, helping with daily activities of life: help with groceries, cleaning, and washing up. Often these types of discussions ignore these practical solutions. There is no one who can send someone into the home to provide practical support.
- Improve employment opportunities and access for the unemployed and underemployed.
- Engage and assimilate immigrant communities and provide for their basic needs.
- Address families' basic needs and problems. Housing should be part of prevention. Housing is very expensive. Parents worry about how to pay rent. Move people into stable environments. A priority should be to set aside money for housing assistance. Employers need to be at the table. Unemployment is one of biggest problems.
- Look at each client-child uniquely and consider cultural issues and spiritual issues Some may need housing, some may need food. Have accountability to the family.
- Provide emergency funds to help families to create breathing space.

Build Resiliency

- Fund services for children 0-3 or 0-5 and their families. The stronger the parent-child relationship is, the better the child can survive the ups and downs of life.
- Provide parenting support groups rather than parent education. Participants can define what issues are important to them and when to receive the information.
- To work with stressed families in the African American community, sometimes a backdoor approach is needed to bring people into services. ISOJI in Marin City initiated a dancercise program twice a week at the local community center. People came with their children and the program provided nutritious snacks. After a few weeks, when trust was built, the group segued into a support and education group. It only lasted six weeks, but made a difference.
- Take a holistic approach, such as Youth Parent Training, to help new mothers with parenting when there are more profound issues happening such as incest, violence, etc.

- Second Step program teaches about empathy and impulse control, and offers pull-out programs for children who need more support. It also provides training for and individual meetings with parents as needed.
- Focus on promoting mental wellness, as in healthy relationships and social and emotional well-being, as opposed to "preventing mental illness."
- Friday Night Live provides opportunities to build life skills and coping skills with young people statewide.

Resources

- Regional assistance centers can help families with autism and seizures. These centers are beneficial places to educate families.
- Asian Community Mental Health Agency is a resource.
- San Francisco has a plan to integrate mental health and substance abuse services.
- Look at the Adverse Childhood Experiences Study (ACES) in which Dr. Falletti studied Kaiser patients to examine information about child abuse effects on children. It can be found on the CDC website.
- Parents who have been through foster youth training can be a valuable resource.
- What research into successful strategies has been identified and when will it be coming to local communities?
    - **DMH Response (EN):** The draft of the strategies identified through staff research will be included in the draft proposed guidelines that will be released by the beginning of June so that DMH can obtain feedback from stakeholders at the June workshops.
- Use movies as one means to educate families. There are classic movies about families that do not function well. People can relate to characters: for a youth who is always trying to prove himself, *East of Eden* can provide valuable connections.

Question 2: What coping skills and resources can be provided to children and youth from stressed families, especially those who are underserved?

Build Resiliency

- Positive Indian Parenting curriculum from Portland, Oregon has had very good results on families from all cultures. It changes attitudes toward children, which is part of why children are at risk.
- Pasadena has a program called Dinner on the Table, which frees up teen mothers one day a week with a family activity to bond the family. The entire family can have a need met at one location. It offers a parent-child component.
- Home Boys and Home Girls programs in Los Angeles help youth in trouble and give them a job. It is like an apprenticeship program and teaches them to care about the business where they work.
- Look at family strengths and build on them.
- Teach self-advocacy skills and resources for stressed youth and families to advocate for themselves. Develop educational programs for self-advocacy.
- Schools should develop programs to implement children's resiliency skills. As issues change in the upper grades, services are scattered and not systematic.

- Having a mentor who offers encouragement promotes resiliency later in life.
- After school programs can involve teaching something socially to children in all economic classes.
- Provide a safe place for children, such as after school programs. Children need a place where they can debrief. Schools do not have the ability to do this. Such a place should require parental involvement.
- Involving children and youth in doing something positive for someone else can raise self-esteem.
- Take children out of their urban environment where they learn to please adults and put them in nature, a whole different way of dealing with the world. Emphasis would be a reliance on nature rather than emphasis on other people to build a child's self-reliance skills.
- Children need a place to go where they are comfortable and can relax. Offer a place that is normal and stress free with caseworkers if they need to talk. This is akin to children's respite. Chino had such a program.
- Arts activities can let a child know that he or she is good at something.
- Activities like soccer are great to involve children in groups.
- Arts, sports or something children find so that they can test themselves is a lot like being in nature. These are a world apart from dealing with adults and children, in which children can be successful in another way, mastering skill, knowing a place, science, etc.
- Establish a connection between the child and an activity that is a concrete success. It is hard for some children to earn a passing grade when they do not care about the subject. But if they can invest meaning, they can do better and have more interest.
- Foster youth in group homes need more recreational therapy.
- Parents can be so involved in a major stress event that their children do not receive education and life skills and social skills in small groups. Teach skills to children who can raise issues with a group of peers and a facilitator. Children learn to develop skills to solve issues.
- Work on socialization issues: self-esteem requires the ability to have one's needs met.
- Children with learning disabilities who have social skills issues in many communities do not have the opportunity to make friends because they are different. This along with the stress of constant struggle at school puts these children at high risk for emotional disturbance. Offer low intensity groups for teens that would help children make friends. Without that, antisocial behaviors can flower.

Offer Peer Models

- Offer peer support groups.
- Support positive youth development and peer mentoring programs.
- Peer to peer support is essential. Provide family resource centers for families to learn about health, medical needs, peer to peer support, child care needs, etc. Parents will then know how to connect with other parents. This is especially important to connect families with infants and toddlers.

Family Involvement and Education

- In Mountain View, they are testing a “family ambassador” model in the Latino community. Parents are being trained about resources for families with young children. It is going well and might be something DMH would want to disseminate. It is funded by First 5 Community Engagement funding.
- Educate parents on how to learn about their child. Sending staff out to the home is an important service to offer to families. Provide funds so that families can attend group services.
- Involve parents in some way, such as knowing what their child did today. Parents need support too.
- Reality programs about nannies can help people who are stressed. Professional nannies are taped as they resolve situations and families can learn from it. This teaches parents to listen and love.
- Offer a program in which a therapist observes parent and child interactions and coaches the parent with an earpiece; this allows parent and child to play and provides feedback.
- Provide parenting education and support.
- Parents who have children with mental health challenges may be presented with standard parenting education that does not work for their family, which makes them feel more isolated.
- Stress in family situations primarily comes from the parents. Address parenting and living skills of parents. Involve whole families. Our mobile society does not have traditional communities or role models that children can look up to. Help to provide a sense of community that is missing from our culture, particularly in large urban areas where it is hard for children to get together.
- Having connection to people is important. Families need to be equal parts of the process and involved from the beginning. Southern California does not have stable communities. A new generation of Asian and white people has not lived here long enough to achieve stability.
- Create a safe environment for parents who are afraid to come forward.
- At IEPs, let parents know what resources are available. Parents can go to the Department of Education or Special Education Local Plan Area (SELPA) themselves. Help parents advocate for themselves.
- Longer term support and therapy is necessary especially when an incarcerated parent is released.
- Fund quality home-based social-emotional support services, using trained and supervised volunteers and paid paraprofessionals for stressed families with young children, which extends for at least one year.
- Will PEI fund assessment for those needs and link parents to those services to help reduce family stress directly or indirectly?

Early Identification and Intervention

- While Early Mental Health Initiative, Primary Intervention Program, and Second Step, are great programs, there are no existing programs to penetrate children early enough. Provide opportunities and tools to help children develop appropriate problem solving skills and abilities to connect with other people in school settings.

- Judy Langford's Strengthening Families through Early Care and Education model is a resiliency model that stresses early care, early education, and outcomes, such as parental resilience and access to support services, etc.
- There are no appropriate existing mental health services for children. There needs to be more funding for prevention starting from the hospital, such as a program through which nurses could assist young mothers to promote child family bonding. New mothers need support in their natural environment. The PTIC program is a coaching interactive program between parent and child.
- Provide early intervention, home-based services to children who are in foster care and children in transition into adoption.
- All children should receive services offered to them at earlier ages. Some parents do not understand or accept the need and need encouragement when they are overwhelmed.
- Maternal depression could be addressed through a screening process, possibly through the nursing program home visit.
- Address perinatal issues and include the father in any assessment and intervention.
- Work with the Childcare Referral Network. By providing education to their staff and volunteers, it is possible to reach children earlier. Generally what is happening in the home is what manifests through the child.

Barriers

- It is difficult to cope with multiple children and other family members with mental illness.
- Where do parents obtain access to these services before they are met by Probation or Department of Family Services?
- Parents are not aware of social services and what they do.
- Teacher's referrals take a long time.
- The biggest fear is that these funds will be spent on fragmented, discontinued programs.
- Effective or evidence-based models may not exist for diverse ethnic communities, such as Latinos or Asians and Pacific Islanders. Evidenced-based models should be modified according to local needs and unique characteristics.
- Generational patterns give parents massive problems, including domestic violence, incarceration, and cycles of abuse.
- Fight substance abuse problems.
- A large cell phone survey of transition age youth showed that youth thought family breakdown was their biggest concern.

Partnerships and Points of Entry

- Explore the New Zealand model process, Family Team. Discussion should be from a "we" standpoint. Access resources by going to the family first and share information across agency lines. Bureaucratic nonsense tends to be the norm here.
- Offer mental health services at school health centers known to be youth friendly and confidential.
- Wraparound is a model program.
- Foster youth and families need more wraparound and home-based services.

- Require more of schools to be an access point.
- Collaboration with schools is essential. Use MHSA to work together with different systems. Share resources and be connected with each other.
- Partner with CBOs, especially those serving specific communities.
- Not all children at risk are in schools: some have dropped out, some are home schooled. Have services at CBOs as well.
- Mandate that partners such as schools, departments of social services and juvenile justice work together. Look at it as leveraging funding.
- Integrate businesses that serve families.

Meet Basic Needs

- In poverty communities, many parents cannot go to family resource centers because they do not have money to take a bus. Provide mobile family resource centers that could go to the families. Through these centers, families can learn ways to impact their own environmental barriers. Los Angeles County had funding for a mobile family resource center through First 5.
- Provide free transportation.
- Child care and transportation are big barriers; offer services close to home.
- Use navigators to link people to broader resources (other social services) and keep up to date on available resources.
- Help parents who have three jobs to pay the monthly bills and still need to maintain a home so that they do not take the stress out on the child.
- Meet children's basic skills.
- Remember Maslow's hierarchy of needs: food and shelter are first steps.

Cultural Competence

- Culturally relevant peer support especially school based can be a universal strategy.
- The growth in California will come from fertility more than immigration. A great deal of stress comes from the generation gap and immigration gap of immigrant families. Pay attention to demographics of California and look at how to bridge the communication gap. Youth policy is critical over the next 20 years.
- Hire bilingual staff.
- Use promotores.

Strategies

- Use modeling, education and building of relationships with stressed families.
- Offer regular, frequent home visits by professionals.
- The old fashioned settlement house model served families well and is worth resurrecting.
- This is an opportunity to look at innovative programs, even ones that are not yet validated.
- Provide "solution-focused therapy" for family members.
- MHSA funds are also to be used in hiring consumers and family members. In PEI this could be a peer of young mothers and youth.
- Include youth development research framework in all strategies and focus areas of prevention.

Resources

- Access to resources is outdated: there is no comprehensive resource list that everybody can use to give out to clients. Update lists that mental health professionals can give to clients.
- Offer free or low cost programs.
- A lot of preschool classes address ADHD. Health resource specialists based in elementary schools will identify children and are already aware of a child's situation because of information from preschool teachers.
- Fund drop-in centers, similar to wellness centers, for families seeking help, for example, in the middle of a parent/child conflict or parent feeling overwhelmed and needing respite.

Training

- School-based services are important. Parents are more likely to accept referrals from a trusted person who works with their child in a school or child care setting. People in contact with families need to feel comfortable with referring a child for help. Train day care providers regarding how to communicate and provide mental health consultation for children coming into child care centers. Provide basic psychological training to day care providers.
- School staff, administrators, and aides spend time each day affecting children's lives and they are not mental health professionals. Educate them about identifying stressed children and positive techniques they can integrate in their curriculum and identifying mental health services in their communities.

Intensity and Duration

- Families dealing with multiple stressors may require higher intensity. This work takes time.
- Short term services for those who need it the most is a good thing, to make the money go further.

Funding Issues

- It is very hard to obtain help for the parents in highly stressed families because they are indigent and do not have Medi-Cal. To qualify for mental health services, a person must be severely disturbed. For example, a mother whose child has severe medical needs is with her child 24 hours a day, because the child cannot tolerate not being with her. She needs help with her interactions with her child and other emotional support.
- Work with existing Medi-Cal policy to raise reimbursement rates to benefit mothers and children. Advocate for reimbursement rates for services to children ages 0-3 to help providers.
- Develop ways to incentivize partners to participate. To make it worth their time: create incentives, not just mandates.
- This is an opportunity to look at the definitions that drive funding. In the early days of substance abuse funding, there was prevention as well as treatment.

E. Onset of Serious Psychiatric Illness

Onset of mental illness is defined in PEI as those individuals identified by providers, including but not limited to primary health care providers, as presenting signs of mental illness, and who are unlikely to seek help from any traditional mental health service. The following points illustrate the range of issues involved:

- The majority of mental illnesses are diagnosed before the age of 25.
- Early detection, assessment and linkage with treatment and supports can prevent mental health problems from compounding and can prevent poor life outcomes from accumulating.
- Early intervention can have a significant impact on the lives of children and adults who experience mental health problems.
- Intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability.
- New understanding of the brain indicates that early identification and intervention can sharply improve outcomes.
- Longer periods of abnormal thoughts and behavior have cumulative effects and can limit capacity for recovery.

Question 1: In your community, what activities, programs and services have been successful to help underserved individuals who are experiencing early symptoms that may lead to serious mental illness?

Programs by Name

- Pathways to Recovery, San Bernardino offers cooking, depression relief, crocheting, Spanish-English and chitchat. It is open to recovery.
- At Pathways to Recovery, consumers are there for each other and take care of each other.
- The clubhouses are planning to implement a One Stop Shop so that the social workers, psychiatrists and clubhouse activities would all be in one place.
- The Substance Abuse Education Programs in Los Angeles provide outreach and education in residential recovery settings in which the staff are oriented to 12 step programs. They trained staff about mental health issues and subsequently found a high percentage of mental health issues.
- Breaking Down Barriers in San Diego is a program that seeks to break down barriers to services. They believe that transforming the mental health system should mean transforming language, because often the terms used are barriers to access.
- NAMI has several model programs: Provider program, Family to Family, Peer to Peer, and Teachers and Parents as Allies, which fosters collaboration between teachers and families. Some are available in Spanish.
- Riverside uses NAMI's Parents and Teachers as Allies to teaching parents and teachers. Teachers do not receive mental health training in their education. The NAMI program is helping them identify mental health issues in their classrooms. It

operates in two school districts in the county. In Minnesota, the program is mandated for every teacher. A peer speaks about mental illness and what it is like to have it leads part of the program. The teachers talk about life in the classroom, working with students with different mental illnesses. It is a as a one session program.

- Wellness Recovery Action Program is universal, tailor-made to a client's need and not expensive to implement.
- Being Frightened is a SAMHSA program worth researching.
- Outreach and engagement to people who are homeless is successful in bringing them AB 2034 services, a model 24/7 wraparound. Many clients come to San Joaquin County's Marshall Gipson program to sleep.
- Support the model anti-stigma campaign, Stamp Out Stigma, and its use of clients. Used in San Mateo County, presentations are done by clients.
- In Our Own Voice.
- Street Sheets are newspapers sold by people who are homeless. Selling these papers could have a lot of power for the people who sell them and because of the content.
- I-Ward at the Contra Costa Regional Medical Center in the late 1970's was an innovative no-medication ward.
- Red Flags is a program started in Ohio in 1997 to raise awareness in schools, among teachers, students and parents, about depression. It provides a unit on depression in the middle school health curriculum, an annual in-service for teachers and an annual parent presentation. It is available in Newark, Fremont and Union City. While it is currently available in San Jose, advocates are facing challenges to introducing this free training into schools. Upper level administrators are reluctant to use it.
- The program Change of Faces receives most referrals from the Department of Children and Family Services. Many of its clients have co-occurring disorders. Along with neglect and abuse, many have experienced abuse that is very old and undiagnosed.
- Team Decision Making in Pomona is a community services program that offers an incredible opportunity to help keep children in their homes. Educators, friends, social workers and pastors come together to problem solve. The Community Council is a place at which the community can talk about child welfare issues related to child abuse referrals.
- Through IDEA, all the people involved with a child with special needs must come together to talk about the child. Early Start is a model of collaboration. Los Angeles has a partnership and early intervention council comprised of early intervention programs and other service providers.
- John George at Fairmont Hospital in Oakland is a model.

Programs by Methodology or Strategy

- A program provides parent education using a community organizing approach. Parent neighborhood groups have grown. This approach can reduce stigma and teach early warning signs.

- Family preservation and family support offers families, who have entered the system for neglect, ways to obtain needed services.
- Wraparound provides a parent partner to help people process and acknowledge what is going on, taking cultural issues into account. People feel alone and parent partners help to diminish that feeling.
- In Orange County, a drop-in center for seriously mentally ill was not well attended. The agency transformed the drop-in center into a mental health consultation site. Two-thirds of the time, people came for just one visit, the remaining third would require a referral. Staff would provide emergency mental health consultations within the larger agency within minutes. If someone talked about suicide, staff would make an emergency assessment and referral.
- Use videos as an education strategy, either for group presentations or as a lending library.
- Fund warm lines. There is one in Marin and San Francisco and Contra Costa, and one coming in San Joaquin.
- People could be taught what onset is and what they should do. Services have to be in a place where there is no stigma attached.
- Provide support and training to Meals on Wheels staff and primary care providers. There are 1,200 home-bound elderly in Alameda County and the population is growing.
- It is important to have mental health providers and outreach staff who know the community they serve, rather than just come in to diagnosis and get out. Meals on Wheels people are from the community of the people they serve.
- So often, the first contact is with the law enforcement. There are some good programs, but we need much more.
- Encourage assessment screens for depression during preventive health care for seniors.
- Have more support groups for adult children of older adults who have a serious mental health problem.
- Start to provide transition services two to three years earlier than currently provided.
- Develop trust with the person.
- Many do not trust outsiders. Train promotores who become leaders. Understand the reality of each specific community.
- Change the language; i.e., “mental health counselor.”
- Create services and programs that factor in issues of poverty and substance abuse, etc.

Peer Programs

- Have peer support specialists employed in counties. They relate to the person on a mutual level and can draw out honest answers.
- San Joaquin County is opening a Wellness center.
- Alameda Network of Mental Health Clients has peer support programs in drop-in centers. Peers are concerned about discrimination and stigma directed to students in schools. It is important to find off campus sites, where children and youth can have access to peers.

- DMH could create a job pool for wellness center workers to rotate around the state. Consumers and families would obtain jobs in this program. For example, park rangers rotate to different parks.
- Train peers, giving them an opportunity to give back to the community, and facilitate their role as a supporter.
- Use peer counselors and pay them for their services.

Programs for Cultural Groups

- Orange County has a community education program with workshops in the Latino community in Spanish, and conducts focus groups about barriers about accessing mental health services. This program collaborates with the Association for Latino Mental Health Awareness. Outreach workers attend the meetings. The program is talking to the School Nurses Association. Community education is a big part, even if no direct services are provided.
- There is not a lot of research for Asian and Pacific Islander communities. This is a shame-based culture, so people often delay seeking help until they are far along their disease process. Agencies conduct outreach and education in settings that are comfortable for them, working with faith-based and school-based programs. Asian cultures' emphasis on academics is a good hook.
- An agency provides outreach to agricultural workers, in fields and schools, to educate them about mental health issues and social services. There was no set curriculum, so they created one from existing models. The agency created relationships with farm workers, who then began to come into the agency's clinic.
- Reach out in small groups. Bring people with different languages together. Then bring new consumers into full service partnerships (FSPs). Speak their language and have materials in their languages.
- Translate DMH materials include Vietnamese, Spanish, Korean and Farsi.
- San Joaquin County provides mental health for Spanish speaking Latinos.
- San Joaquin County has a mental health program for Southeast Asians.
- San Joaquin County has a black awareness program, a First 90 days model outreach to black, transgender, and Native American.
- Use cultural brokers who will link potential clients to more formal services.

Programs for Older Adults

- Department of Aging in Los Angeles does assessment in the home that screens for depression.
- Impact Model in Orange County is a health clinic for uninsured older adults.
- For older adults, there are caregivers support groups to prevent burn-out and elder abuse prevention to repair issues before they get worse.
- Genesis is an excellent program that serves older adults, with triage. It is a primary care collaboration that uses teams of a social worker and nurse to follow up referrals for elder abuse to perform a physical and mental health screening.
- In Los Angeles, first onset for older adults can lead to possible eviction. The county has four vans that go to clients. However, four vans in the county of Los Angeles cannot begin to meet the need.
- Orange County Preventive Health Care for Seniors is a successful program.

- Orange County has a new program at St. Jude's Medical Center for screening for depression in older adults, based on the IMPACT model.
- "Bridges to Health" provides linkages to other services. The Area Agency on Aging uses the program as well.

Programs for Youth

- Riverside's Youth Conference recruited 1,000 youth participants in 2007, and covers many mental health topics. Workshops help youth to understand many issues that have hidden in the closet. The participants "all know someone" with mental health problems. It has been very successful in helping youth know they are not alone. The ones who come are school leaders who then work on activities in their own school. The Conference filled the convention center.
- Many youth do not want to use school-based services, because of stigma. Use sports programs as an entrée and place staff at such activities as Friday Night Basketball.
- Offer college-based psychology services, peer hotlines and peer emergency services for this transition age youth.
- Transition age youth are all different: youth in foster care, youth with diagnoses, youth with learning disabilities and youth with substance use issues. Not all have been traumatized by the child welfare system. This is an important issue in the guidelines in terms of finding programs that will work for the population. Safe Schools, Healthy Students should be in every middle and high school. It uses an intervention specialist and social worker. In one school over the first six months, staff identified 84 children out of 1,000 students with symptoms of mental illness.
- Offer an educational program as part of the high school curriculum.
- Leave schools open at night for multiple activities and services, so that confidentiality can be maintained.

Barriers

- Reduce stigma so that people can make appropriate referrals.
- Many people are not diagnosed until many years after their first break.
- To target early onset, more is needed than to just increase referrals. For example, Orange County filled up all openings for services but did not change the ethnic make-up of the population served. Many people have a duration under psychosis (DUP) of over a year because no one recognizes it. The program is still not reaching the people who are experiencing first break, but instead reaches people with chronic mental illness, who also need services. MHSA has to do something different.
- Children who experience trauma from ages 1-6 are much more likely to experience mental illness; 80% use drugs to self-medicate because trauma and drugs affect the same part of the brain.
- Many professionals do not want to live in rural areas.
- There is nothing for people with developmental disabilities.
- There is an issue of "liability" for schools, if they identify depression and the person commits suicide.
- Inyo County has more problems than solutions. While Inyo is the second largest county in terms of land mass, it has a population 18,000 people and distances of

160 miles between cities. It is difficult to recruit professionals to work there. Agencies are trying to outreach to Latinos and Native Americans and are developing wellness centers. In Bishop, MHSA programs are just beginning to reach out to the homeless, to provide for laundry and showers. Teachers do help to identify children and youth with symptoms of onset.
- Very few services are available.
- Physicians do not ask about substance abuse because there are no treatment services.
- DSM IV does not address children well and many fall through the cracks as a result.
- Transportation is a problem for parents. Parents would benefit from bringing other community organizations on or near school campuses.
- The mental health field has not developed needed treatment services and new treatment modalities.
- Individuals are released from involuntary hold and fall through the cracks at a time when they need a bridge to mental health services.
- Some clients may have insurance and may be able to access some services through their insurance.

Family Issues
- There are families with multi-generational mental illness, which has gone untreated because of denial and cultural rejection of concepts of mental illness. Even parents who are teachers and counselors who have the same issues as their children must overcome strong cultural training and denial to acknowledge that they must help their child, and in order to help their child, they must help themselves.
- Sometimes when parents first find out that their child is ill, there is a challenge with follow-up. Because of the initial shock, there is a certain amount of denial.
- Families often go through a grieving process that can take a long time when they learn about their child's illness.
- Many parents do not want to come forward about their own symptoms because they fear their children will be removed.

Evidence-Based Practices
- There are a number of successful programs from foreign countries, but these may not work at all in California, because of its diversity. But their approach is to provide education and access to services and then transport people to those services when they need to. Some people may have one break and receive sufficient services and never need to return. MHSA needs to create its own evidence. Make an investment in evidence based practices in implementation and share information among the counties.
- There are many successful international models in Australia, Canada and England. The United States lags behind in research into evidence-based models.
- UCSF is doing research into early intervention in psychosis, as are UCLA and other universities across the country.

Physical and Mental Health Integration
- Integrate mental health and primary care clinics.

- Partner with primary care clinics which have captive patients and provide opportunities to intervene before onset.
- Primary care providers are trying to find different models for family practice settings. Providers can identify clients with mental health issues, but often have difficulty finding services for them. It is hard to serve the uninsured. There is the potential to work with frequent users of the emergency room. Identification through the emergency room is possible because often consumers have no other resources.
- Integrated behavioral health and primary care are successful at addressing psychiatric illnesses such as depression, anxiety and substance abuse at a less intensive level of mental health services.
- Reimburse primary care providers for the mental health services they provide.
- Many community clinics have a relationship with county mental health and psychiatrists.

Partnerships

- Use access points such as churches, temples, schools and primary care.
- A Baptist church serves all monolingual clients with mental health professionals. It acts as a bridge to mental health services.
- Integrate faith-based agencies. Many of these are very well organized, but they lack sufficient funding.
- Marin County agencies are working through churches with children and families to provide early wraparound services.
- The California Rural Indian Health Board is a good connection for gaining access to Native Americans.

Training Needs

- Therapists need more training by paraprofessionals on complex child issues.
- Improve capacity of primary care physicians, midlevel providers, nurses and medical assistants at clinics.
- School staff need skills to work with students.
- Train gatekeepers – physicians, pastors, postal workers, Meals on Wheels drivers – in senior settings to recognize late onset delusional disorders.
- In one school district, junior and senior high school children and youth are identified for inconsistent attendance or falling asleep in class. The staff can then refer them into the AB 3632 program. Teachers need training to identify children and youth early.
- Teachers understand the range of human behavior and can identify those behaviors that are outside of the normal range, but they need more education.
- Advocate adding psychological training to teacher credentialing programs. There should be more than just one lecture in teacher training programs on mental health issues.
- Foster and adoptive children are underserved. Mental health professionals are not trained to see the nuances of layers of issues which might hinder children from becoming prepared to learn to be successful adults.

Question 2: How can family, close friends and other community members, help to recognize and respond to early signs of serious mental health problems.

Barriers

- It is not our job to tell people what mental illness is but to get them the services they need.
- Psychiatrists often have no clue about their clients, how they eat, whether they are homeless. Psychiatrists often live in expensive houses, while the clients they serve often live in board and care facilities. These facilities are places where one can really learn about mental health.
- Confidentiality is important but it can also be a hindrance to coordination and collaboration.
- The mental health field hops from one theme to another over time. Once it was co-occurring diagnoses, then GLBT, now onset.
- People who support the behavioral model do not believe the people who support the psychosocial model and vice versa.
- Reassess society's whole attitude of what a crisis is. The Chinese character for crisis is the combination of danger and opportunity. The more people see the opportunity within the danger, the better. It could lead to decreased reliance on 5150 situations.
- The chemical imbalance theory does not take into account such issues as exposure to trauma or complications from physical illness. Suggesting that mental illness is equivalent to diabetes or cancer is too simplistic and is not helpful in reducing stigma. Professionals should not ask the individual, "What's wrong with you?" Instead they should ask, "What happened to you?" Let the person talk about his or her own story.
- The language used is an issue. There must be some way to talk about and promote "healthy living" and not thinking only about "disease."

Assessments

- Create or adopt fairly simple assessment tools to identify mental health issues and then use them as a baseline. Ask questions like, "If these issues or feelings are going on, maybe you should talk to someone." Make the assessment available in the community.
- Simple assessment tools exist. The trouble is implementing them consistently by primary care, colleges, and pediatricians. These tools need to be well accepted in the community. Then those who administer the assessment need to know what to do when someone is identified with symptoms of mental illness.
- There are many primary care providers screening tools. However, primary care providers cannot agree on one. Even psychiatrists cannot agree. Then they do not use it. Screening tools are often not culturally competent for the diversity of California.
- Primary care providers can do assessment, but not all the follow-up, which should go to a mental health provider.

Systems Changes

- City and county agencies need to work together.
- Increase services and providers for Medi-Cal and indigent care programs.
- Examine the systems structure of mental health services to detect silos and barriers.
- Work with trained professionals to recognize problems.
- What services are available for adolescents? Is the juvenile justice system the only alternative? Some children and youth are a danger to themselves and/or others and yet help is hard to find for them before they do the harm. These issues raise questions about the rights of the individual vs. the rights of everyone else around them.
- The system needs to change if MHSA is going to change families, close friends and community members and increase referrals. People need to receive what they need the first time not wait until one is held on a 5150 involuntary hold. The system must have what people need when they need it.
- Involuntary holds or 5150 should not be the first treatment. People who are admitted for involuntary hold do not receive treatment anyway.
- If families go to county mental health, county mental health has to be ready to receive them.
- Sometimes parents have to work hard to make schools understand their child's mental illness.
- Those with alcohol and drug problems have to be sober and clean before they get services.

Community Education

- Mental health advocates must become part of different community coalitions to educate coalition partners about mental health issues.
- Educate about the signs of first onset and mental illness, through media, schools, teachers, parents and the public in general.
- Disseminate information to people so that people can look out for each other.
- Certainly clergy should be included: they often know about life changes facing their communities. They need to know what to do.
- Educate the community about where to refer people with mental health needs. Many people do not know where to go.
- "211" in Orange County is a useful helpline that can refer people to services they need. It is an information resource center.
- There are hundreds of family resource centers throughout California; the issue is having a way to have the information to make referrals. There should be a way to centralize information in the family resource centers.
- Offer Psych 101 in the high school level.
- The California Mental Health Planning Council lists high schools and middle schools that provide mental health presentations.

Involve Community

- Community is essential: the more we can expand the community, the better, to decrease isolation.

- Identify close friends, community leaders and others who have the understanding that mental health issues affect the whole community. It takes a consciousness raising approach.
- Include employers as well as families and close friends.
- Work with cultural brokers, the activists in their own community to build trust.
- Community Action Committee in Orange County includes clients and family members who share information.
- Communication, psychology, caring can all be found in a self-help community.
- Use promotores.

Parent Education

- Help parents identify early signs of serious mental health problems in their children, as symptoms often mimic developmental phases; i.e., "terrible two's," "moody adolescent," "rebellious teenager," etc.
- Parents need more information on mental health.
- Parents of low-income families and communities of color do not know where to obtain help. Sometimes advocates forget that people do not know how to access services. School nurses do not want to use the suicide screening tool because they do not know what to do when the response is positive. Agencies often do not know how to make other referrals.
- Caregivers, whether a parent or parent with an adult child, or adult child giving support to parent, need to recognize that their loved one is having issues. There needs to be a mechanism that addresses their issues.

Education at Schools

- Schools are a good place to start.
- Use the National Institute of Mental Health's (NIMH) free download of "The Science of Mental Illness." It is an interactive six-session curriculum for 6 – 8 grades to help students gain insight into the biological basis of mental illness. It just came out in January.
- A "Rise Above Stigma" panel goes out and does presentations. Parents join them as they go out to San Jose State University and Stanford as well as do presentations to middle schools. The information they give out is valuable. Each person at a presentation has met a person with a mental illness. Connecting with that person makes them question their own stigma. Virginia Tech professors recognized something was wrong, but did not know what was available or where to refer this individual.
- Write your child's Individualized Education Plan (IEP) yourself.

Media and Technology for Education

- Air public service announcements (PSAs) on TV programs parents watch.
- NetworkofCare.org is a great resource.
- If there is going to be a statewide program, there should be a website. AARP addresses this.

- Has any level of targeted outreach been done via web-based mechanisms; i.e., chat room discussions, facilitated by a mental health professional or online? This virtual outreach and prevention education is the wave of the future.
- Be creative in reaching young people. Use text messages, music, etc. Many of the people who need mental health services or early intervention and prevention do not have access to the Internet.
- While there are universal emails about prevention of strokes and heart attacks there are no emails about prevention of mental illness or what to look for in psychotic break. Until society starts caring about mental health, people will not acknowledge their mental health issues.

Reduce Stigma

- Overcome stigma and denial. Bring family members into the workforce and have them be part of outreach and engagement.
- Many people do not acknowledge that they have a problem that could be addressed because of denial.
- Reduce stigma so that people can address mental illness.
- Stop stigma in the schools. Schools can fail children, especially those from poor families.
- Mental illness is a shame in the Latino community; being "crazy" is unacceptable; depression in men is considered a sign of weakness. In regards to available services, there are few providers who speak Spanish, even after the individual is ready to seek care.

Other Strategies

- Early intervention should be like care for a person having a heart attack, with immediate treatment for the person.
- Respite care is a healing mechanism.
- Think about our military coming back from Iraq with PTSD. Within the priority populations, veterans could be considered stressed families or families experiencing trauma.
- Keep it simple.
- This happens to anybody, any place, any time, whatever the financial level.

F. Children and Youth at Risk of Juvenile Justice Involvement

The MHSOAC defines this priority population as "those at-risk of, or who have had first point of contact with any part of the juvenile justice system with signs of behavioral and emotional problems."

Prevention and early intervention should be made available to at-risk youth before they become involved in the juvenile justice system; however, years of under-funding and lack of resources in the public mental health system have contributed to the increased presence of these at-risk youth in the juvenile justice system.

Ideally, youth who are beginning to exhibit delinquent behavior should be identified and referred to appropriate services before they get into the juvenile justice system. Positive youth development programs that are aimed at understanding, educating, and engaging children in productive activities should be offered to these youth and their families as early as possible.

Children and youth at risk of juvenile justice involvement might also be represented in one or more of the other prevention and early intervention priority populations.

Question 1: In your community, what are the main issues that contribute to children and youth getting involved in delinquent activities?

Family Contributors

- Lack of role models.
- Youth, with no positive family role models looking for a place to belong, find gangs.
- In dysfunctional families, the child needs attention and often does something wrong to be noticed.
- The majority of men and specifically men of color in the system suffer from another type of trauma: no father in the household. There is a strong correlation of men in the system having no father and yet this might not fit the definition of trauma. Many of these men spoke of stereotypes related to their ethnic identity.
- Removal of the child from the home. There is grief and loneliness in separation from home.
- Methamphetamine is a crisis. When parents use, children may also, and may be placed in group homes. Children with parents who are substance abusers need earlier interventions. They first manifest issues at school, and by the time probation sees them the problems are critical.
- Phoenix House has found that substance abuse by child or parent, lack of support, incarceration of parents and family members can all have adverse affects on children.
- Substance abusing parents are a big problem.
- Parents do not know what to do about their child in trouble with the law. Parents become stressed about the well-being of their child.
- Dysfunctionality of the family, with family members already involved in the justice system.
- Family neglect and lack of supervision can be caused by parents who are themselves in the justice system or are unavailable because they are working all the time. Youth need information earlier in their lives about what not to do in schools, delinquent behavior, and the dangers of alcohol and drugs.
- Abused and neglected children have high risk factors of entering the juvenile justice system.
- Some families do not speak English.
- Families need to understand that they cannot rely on CBOs or probation to take care of their problems.

School Contributors

- School failure is a primary problem.
- Teachers and schools think a child's behavior is only a discipline problem. It is important for parents to be involved with schools.
- Often emotional problems emerge from an untreated educational problem.
- Youth become involved in juvenile justice because security on campuses hear things about the youth that may not be true but which fall into the policy of zero tolerance.
- When mental health needs are not identified, too often the child is expelled from school. It is harder to see that it is a mental health issue once in the juvenile justice system.

Economic Contributors

- Economics is a big issue: children turn to stealing, selling drugs, etc., to support families.
- Poverty.
- Families that do not qualify for the income level of Medi-Cal do not qualify for services until the child gets into trouble. Families need early services, before their child becomes involved, not when they do something wrong. Services are needed for the family as a whole.
- Homelessness.
- Some youth are taking grant money to sell drugs and drop out of school. Jobs are needed.

Community Contributors

- 85% of youth in Santa Clara juvenile hall are victims of trauma and have terrible educational histories.
- PTSD.
- Gang activity is sensationalized by the media. Instead, words from a mother and family support are needed. Plan short and plan long: youth need to set goals.
- Glamorization of gangs and drug use can lead to juvenile justice involvement.
- Stigmatization of mental illness. No one (especially children and youth) wants to be characterized as having a mental illness.
- Society makes everything very criminal.
- Children and youth are under extreme pressure.
- In Los Angeles County, there is a lack of supervision, lack of recreational activities and employment opportunities. On the other hand, there is an availability of drugs and alcohol to minors. Schools too often fail youth, which creates depression. Public health model, which takes into account community issues such as poverty or lack of after-school programs, is useful, as are public health strategies that occur on a community level, especially prevention.

Lack of Services and Programs

- Youth "age out" of juvenile system and then do not have services.
- There is a lack of services for children of incarcerated parents, or gang involved parents. These children are at high risk.
- Lack of supports (not necessarily needs based).

- Budget cuts for many programs. Rebuilding the relationship between children and youth once a program has been cut is not easy. Programs need to be more functional.
- Lack of screening tools.
- Lack of early intervention.

Systems Contributors

- Using the Massachusetts Youth Screening Instrument ((MAYSI), a brief screening tool to assist juvenile justice facilities in identifying youth who might have special mental health needs) found 80% of 1,200 Santa Clara County youth had a diagnosis of trauma or depression. There is a pattern of stress, lack of supports, no early identification, and no early services.
- If a person has mental illness, that person needs services. Services stop as soon as the youth enters juvenile hall. There is help before and after, but is critically needed during incarceration. Juvenile halls are turning into facilities for youth with untreated mental health illness because no services are being provided.
- Contact with Los Angeles county sheriffs is problematic. Their reactions vary based on location of incidents, separating rich from poor neighborhoods.
- Many children and youth are initially diagnosed at the juvenile hall. This should have been taken care of before. It is not really Probation's job to diagnose mental health issues.
- DMH needs to have different mind set.
- When some students are expelled, they go to county schools, rehabilitation, substance abuse and anger management courses. Expelled children who have not been involved in juvenile justice are a part of the target population. Many have no transportation, no school and no counseling for their behavior problems. Most districts have rehabilitation plans but need prevention.
- Families ask for help, but are told their situation is not dire enough. Their problems are minimized and the family becomes dysfunctional.
- The juvenile justice system is not set up to rehabilitate children; rather they are treated like prisoners. The background and experience of youth are not examined. There are no programs for these youth that offer alternatives, or strengthen protective factors.
- American Indians are spread over the Los Angles basin, experience poverty and youth involvement in gangs. Outside factors contribute to why youth get involved. Intake and social workers assume, they do not ask. Provide services to American Indians on rural reservations. The focus in Los Angeles is to deal with its large urban population, but DMH needs to focus also on rural areas.

Assumptions about Youth and Juvenile Justice

- There are youth involved in delinquent activities that avoid the juvenile justice system.
- Putting youth in juvenile hall does not mean they will learn their lesson and be okay when they come out.
- There is a presumption that youth at risk of juvenile justice involvement and youth involved in delinquent activities are the same.

- A child with no Medi-Cal, no insurance, and no services will probably be raised in the juvenile justice system.
- Youth under 25 need long-term involvement and engagement to reduce likelihood of getting back into the system.

Strategies
- An evaluation is done of every child in the juvenile justice system in Alameda County.
- Invest in family engagement.
- Teach coping skills and provide community services.
- Offer after-school programs for youth 12 years and older. Youth have too much free unsupervised time after school.
- Identify children early and uncover trauma (violence in home, in neighborhoods, gangs).
- Program at Edgewood works on stigma.
- There are great programs: Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST), Functional Family Therapy (FFT) used for chronic offenders, and early intervention.
- Is Success Camp a program that, while it has no screening or assessment, works anyway? Children and youth learn how to handle teachers and peers in this program.
- The mental health of the provider is important too.

Start Earlier
- Start at earlier ages, so children and youth do not become involved in juvenile justice in middle and high school.
- Children can be identified at early ages.
- How do we intervene in child's life before they get into system?
- Children are left behind by multiple systems and are exposed to violence and trauma in their home and community. These issues are not being addressed early in life, for variety of reasons, including absent parenting (working two jobs, etc.). Early intervention for family is needed.
- Discuss maladaptive issues. There is a lack of pro social interaction. Start with younger children.

Work Together
- Parents, teachers and foster care need to get out of these silos.
- Everyone must work together. Community mapping is needed about what exists now. Avoid duplication of effort and gaps in services. Services should be more comprehensive.
- How can public health work with everyone to mitigate an assured course for failure, as seen in the percentage of young children who will get involved in the juvenile justice system, based on school performance and expulsions?

Need to Build Resiliency
- Youth need a spiritual foundation.

- There is abundant research on criminogenic risk and protective factors. Dedicate resources to fostering protective factors that will keep youth out of the system. Serve youth in a broader way.
- A growing percentage of youth become involved in the juvenile justice system out of fear within the environment of threat in schools.
- First break can lead to involvement in criminal behavior, with feelings of isolation from peers, lack of understanding, wanting to prove themselves, peer pressure, being victimized by their peers.
- Children and youth often go to peers for help instead of family.
- In stressed communities, there is a sense of societal loss and grief. There is a loss of hope or optimism among children and youth that leads to depression. Optimism, resiliency and recovery need to be included as does mentoring.
- Pro-social activities are important.
- Boredom and not enough positive activities in the community.
- Girls at risk go into drugs and prostitution out of boredom.
- Children and youth need a lot of activity and structure but are overlooked from a young age.
- Use community members with peer expertise to address drugs and violence. Unidentified mental health needs lead to self-medication.

Outcomes

- There are high rates of transient children and youth in juvenile justice. Measurable outcomes are needed.
- Quality Measurable outcomes are needed. The child should be better after services.
- The objective is rehabilitation in juvenile probation.

PEI Requirement Issues

- Mentally Ill Offender Crime Reduction (MIOCR) grants were awarded to 23 counties. Consider using PEI dollars for the remaining counties.
- If the treatment is supposed to be voluntary, motivation is needed for the child to participant.
- Only 51% of funding dedicated to people 0-25 is not much money. Based on research evidence, all funding should go to children and youth.
- A broader look at prevention and early intervention is needed.

Inclusion in Target Group

- The time between ages 0-20 is almost by definition the time for prevention and early intervention. Invest in social supports for this age group. Youth are still children in many ways even after “age of majority.” There is substantial research on programs that help with recidivism. If mental illness is present and a person has no Medi-Cal, it is hard to eliminate barriers. Youth are sent through a revolving door.
- There is a big difference between children and youth who are part of the juvenile court system under section 300 (minors who are alleged to have been neglected or abused by their parent or guardian) and those who are involved under section 602 of the Welfare and Institutions Code (all delinquent minors who are alleged to have committed an act that would be criminal if he/she were an adult). However, placing

them in proximity may turn the “300s” into “602s.” Children and youth who need mental health services and do not receive them too often end up in juvenile hall, the last resort. While there are some services, there are not enough.
- With so much research on brain development, expand the age group to span 0-25.
- Youth who are not diagnosed by the DSM IV need to be identified. Address the child, not as the student based on his or her academics.
- Youth with ill parents, etc.
- Youth emancipated from foster care.
- 25% of people in Santa Clara County jail are under age 25.
- Mental illness emerges across the lifespan.

Define Terms
- Once a youth has had first contact, PEI cannot serve him or her. Does this mean youth on probation or youth in juvenile hall? At risk of delinquency (no prior vs. at risk of entering the juvenile justice system). Does this exclude a population? The definition of terms is critical. Mental health issues and delinquency issues are not the same.
- Definition of terms is essential. For example, at risk of failing at school, or at-risk child having problems at home, joins gang, dysfunction in the family. How is mental health defined, narrowly or broadly?
- Other terms needing definition include immigrant and refugee, intergenerational and acculturation. Programs for these youth getting involved in delinquent behaviors are needed.
- The term “at-risk” needs to be clarified. Emerging mental health issues and juvenile delinquency do not always go hand in hand. Assessment is often missing.
- Clarify the definitions of mental health vs. delinquency. There is an overrepresentation of African American males with emotional disturbance. Look how professionals define the behavior of students.
- The juvenile justice system routinely uses the terms "at risk," "prevention" and "early intervention." However these terms are used to describe youth who are "at risk" of involvement in the juvenile justice system and "prevention" and “early intervention" are used to refer to strategies to prevent or intervene in a youth's criminal behavior, rather than their mental health problem. Because the PEI process is bringing together people from several different disciplines, it is important to define terms, which is beginning to happen at these stakeholder workshops. For example, a youth could be appropriate for mental health prevention strategies and at the same time be appropriate for juvenile justice prevention strategies, or he/she could have a mental health diagnosis, be severely emotionally disturbed but still be appropriate for juvenile justice prevention services, or the youth could be appropriate for mental prevention but already have prior juvenile justice involvement. The mental health issues and the juvenile justice issues are not necessarily on the same track.
- This priority population should read “at risk of or in juvenile justice.”
- Clarification is needed on the adult population involved in the juvenile justice system.

Question 2: What partnerships could be formed in your community to better address the behavioral health needs of children and youth at risk of involvement in the juvenile justice system?

Partnerships

- Mental health is the only component missing from partnerships. Mental health in juvenile halls and assessments are needed.
- Juvenile justice and local mental health and CBOs to provide services before juvenile justice enters the picture.
- Most children and youth in juvenile justice are at home or in the community. CBOs help keep them at home
- Need people trained in mental health in the juvenile justice system because parents have distrust in the system.
- Leverage policies, collaboration, and commitment to change. Develop clear guidance on mutual accountability on outcomes between agencies. Offer screening and assessment at both substance abuse and mental health levels.
- Open mental health resource centers and work with Mental Health, Probation, and Social Service. Use SAMHSA, Safe Schools and Healthy Students funding. In education there is not enough socio-emotional learning. Suspension and expulsion are not good interventions because they keep the child at home.
- Church, civil organizations and voluntary associations are alternatives to the juvenile justice system.
- Parks and recreation.
- Libraries.
- Schools. However, note that special education funding is limited.
- Mental health and school staff need education and training.
- Remember preschools: over 70% of youth in juvenile justice system had been in out of home situations.
- Primary care, juvenile probation, entire family, transition age youth, Health & Human Service agencies, Alcohol and Drug Programs, school system, and other providers need to work together.
- School based health centers. Look at research on youth development and resiliency for children and youth.
- Look at the System of Care approach: collaborate among all human service agencies where the child can get services.
- Address capacity by enhancing partnerships that already exist and build on what exists.
- Family preservation's wraparound services are needed for families who need stabilized home environments.
- Ethnic community agencies are needed where the whole family can receive culturally appropriate services.
- Legal advocacy organizations.
- Probation cannot do this job alone; it needs access to services and assessments. All systems need to be involved.
- Involve the criminal justice system.

- Increase the number of transition age youth roundtables at which youth talked about what worked and did not work for them.

Other Solutions

- Possible means to reduce recidivism include early diversion, facilitated transition to community, MST model, strengthened assessment, and diversion for youth aging out of foster care.
- There should not be a line between prevention and early intervention. Look at Alcohol and Drug Programs prevention programs. Integrated services are good. Do not reinvent the wheel.
- Children need to be a partner along with agencies. What about the children and youth with siblings in the juvenile justice system?
- Engage the young people. Be creative and innovative.

Programs and Services by Name

- Integrate services between dual diagnoses. The Mental Health Court is a good model; it can decriminalize mental illness.
- Collaboration between a Pasadena mental health center and the Pasadena police department keeps recidivism down. Counseling, parenting classes, and mentoring are offered.
- Pathways to Recovery, a program for transition age youth in San Bernardino County, provides mental health, food, clothes and transportation. It is very inviting for youth to participate in.
- Mother's Advisory Committee talks once a month to law enforcement about youth.

Concerns

- Many of these youth have no access to health services due to lack of Medi-Cal or other insurance.
- There has been a shrinking of resources in schools, not just in poor communities.
- There are preschool children who are already having problems communicating socially. Do not just say, "Oh, they are just children."
- Most parents and families do not think of collaboration for the child's benefit. Identify there is a mental illness and partner with community agencies to keep the child out of the system. There is a gap being created around the definition.
- Do not only form the partnerships, but also explore how different systems learn to work together, such as terminology used by different systems, etc.

Comments about Juvenile Justice Questions

- The breakout questions are too simplistic.
- Question 1 is not going to bring any light to the problem. Youth are getting involved without committing any delinquent act.